

Health and Recovery Services Administration (HRSA)



HRSA-Approved Family Planning Provider

Billing Instructions for:

- **Reproductive Health Services**
- **Family Planning Only Services**
- **TAKE CHARGE Services**

[Chapter 388-532 WAC]

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About this publication

This publication replaces all previous HRSA Family Planning Services Billing Instructions, TAKE CHARGE Billing Instructions, and Numbered Memoranda, including 01-53 MAA, 01-66 MAA, 03-76 MAA, 04-37 MAA, 04-105 MAA , 05-05 MAA, and 05-44 MAA.

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Important Contacts

A provider may use HRSA's toll-free lines for questions regarding its programs; however, HRSA's response is based solely on the information provided to the [HRSA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern HRSA's programs. [WAC 388-502-0020(2)].

Who do I contact to obtain information on becoming an HRSA-Approved Family Planning Provider?

Family Planning Program Manager:
Phone: (360) 725-1664; or

TAKE CHARGE program manager:
Phone: (360) 725-1652

Who do I contact if I am an HRSA-Approved Family Planning Provider and I want to submit a change of address or ownership, or find out about the status of a provider application?

Provider Enrollment:
<http://maa.dshs.wa.gov/provrel/> or
Phone: (866) 545-0544 (toll free)

Who do I contact if I am a TAKE CHARGE provider and I want to submit a change of address, phone number, or fax number?

Family Planning program manager:
Phone: (360) 725-1664; or

TAKE CHARGE program manager:
Phone: (360) 725-1652

Where can I get the TAKE CHARGE Pre-Application Worksheet or the TAKE CHARGE Client Application form DSHS #13-703?

To **download** DSHS forms, visit:
<http://www1.dshs.wa.gov/msa/forms/eforms.html>
scroll down to form # 13-703.

To **have a copy mailed**, contact:
DSHS Forms Management
Phone: (360) 664-6047 or
Fax: (360) 664-6186
Include in your request:

- Form number and name;
- Quantity desired;
- Your name and your office name; and
- Your full mailing address.

How do I obtain information regarding the Family Planning program?

Visit the Family Planning Resources link on HRSA's web site:
<http://maa.dshs.wa.gov/familyplan/>

E-mail the Provider Relations unit:
providerinquiry@dshs.wa.gov

Family Planning program manager
Family Services Section
PO Box 45530
Olympia, WA 98504-5530
Phone: (360) 725-1664

HRSA-Approved Family Planning Providers

Where do I obtain information regarding the TAKE CHARGE program?

Visit the TAKE CHARGE page on HRSA's Family Planning web site: <http://maa.dshs.wa.gov> (select the *Family Planning Resource* link.)

Email the Provider Relations unit: providerinquiry@dshs.wa.gov

TAKE CHARGE program manager
Family Services Section
PO Box 45530
Olympia, WA 98504-5530
Phone: (360) 725-1652

TAKE CHARGE Eligibility Unit
PO Box 45531
Olympia, WA 98504-5531
Phone: (877) 787-2119
Fax: (866) 841-2267

How do I submit my client's TAKE CHARGE applications on-line?

You must be registered with HRSA to submit your client's TAKE CHARGE application on line. To register with HRSA contact:

Family Planning Program Manager
Phone: (360) 725-1664

How do I find out about internet billing (Electronic Claims Submission)?

WinASAP and WAMedWeb
<http://www.acs-gcro.com/>
Select *Medicaid*, then *Washington State*

All other HIPAA transactions
<https://wamedweb.acs-inc.com/>

To use HIPAA Transactions and/or WinASAP 2003 enroll with ACS EDI Gateway by visiting ACS on the web at:

http://www.acs-gcro.com/Medicaid_Accounts/Washington_State_Medicaid/Enrollment/enrollment.htm

or by calling: (800) 833 2051.

Once the provider completes the EDI Provider Enrollment form and faxes or mails it to ACS, ACS will send the provider the web link and the information needed to access the web site. If the provider is already enrolled, but for some reason cannot access the WAMedWeb, then the provider should call ACS at (800) 833-2051.

Where do I send my hard copy claims?

Division of Program Support
PO Box 9247
Olympia WA 98507-9247

Who do I contact if I have questions regarding...

HRSA policy, payments, denials, general questions regarding claims processing, or HRSA Managed Care?

Provider Relations
<http://maa.dshs.wa.gov/provrel>
Phone: (800) 562-3022 (toll free)

Private insurance or third-party liability, other than HRSA Managed Care?

Coordination of Benefits Section
Phone: (800) 562-6136

How do I obtain pharmacy information?

HRSA's Pharmacy Web Site:

<http://maa.dshs.wa.gov/pharmacy/>

Prescriptions By Mail web site:

<http://www.medco.com>

Providers Call: (888) 327-9791

Clients Call: (800) 903-8639

Or go to HRSA's web site:

<http://maa.dshs.wa.gov/RxByMail/>

How can I obtain copies of billing instructions or numbered memoranda?

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Definitions

This section defines terms and acronyms used throughout these billing instructions.

Acquisition cost - The cost of an item excluding shipping, handling, and any applicable taxes.

Ancillary services - Those family planning services provided to TAKE CHARGE clients by HRSA's contracted providers who are not TAKE CHARGE providers. These services include, but are not limited to, family planning pharmacy services, family planning laboratory services, and sterilization surgical services. [WAC 388-532-710]

Applicant - A person applying for TAKE CHARGE family planning services.

Application assistance - The process a TAKE CHARGE provider follows in helping a client to complete and submit an application to HRSA for the TAKE CHARGE program. [WAC 388-532-710]

Certified full fee - A family planning clinic's actual acquisition cost plus dispensing fee for a product purchased through 340B of the Public Health Services Act. This is the same amount as reported annually to the department of health. [WAC 388-532-050]

Client - An applicant for, or recipient of DSHS medical care programs.

Code of Federal Regulations (CFR) - Rules adopted by the federal government.

Community Services Office (CSO) - An office of the department which administers social and health services at the community level. [WAC 388-500-0005]

Complication - A condition occurring subsequent to and directly arising from the family planning services received. [WAC 388-532-050]

Contraception - Preventing pregnancy through the use of contraceptives. [WAC 388-532-050]

Contraceptive - A device, drug, product, method, or surgical intervention used to prevent pregnancy. [WAC 388-532-050]

Core Provider Agreement - The basic contract that HRSA holds with providers serving HRSA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

Department - The state Department of Social and Health Services. [WAC 388-500-0005]

Dispensing fee - The fee the Health and Recovery Services Administration (HRSA) may reimburse family planning clinics for expenses involved in acquiring, storing and dispensing contraceptives which are reimbursed at actual acquisition cost. [WAC 388-532-050]

Education, Counseling, and Risk Reduction intervention (ECRR) - A stand alone HRSA-designated service specifically intended for clients at higher risk of contraceptive failure, that strengthen a client's decision-making skills to make the best choice of contraceptive method and reduce the risk of unintended pregnancy. [Refer to pages C.13-C.15 for further information on ECRR services and WAC 388-532-710.]

Explanation of Benefits (EOB) - A numeric message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Family Planning Only program - The program providing an additional 10 months of family planning services to eligible women who have just ended a pregnancy or completed a delivery. This benefit follows the 60-day postpregnancy coverage for women who received medical assistance benefits during the pregnancy. This program's coverage is strictly limited to family planning services. [WAC 388-532-505]

Family planning services – Medically safe and effective medical care, educational services, and/or contraceptives that enable individuals to plan and space the number of children and avoid unintended pregnancies. [WAC 388-532-050]

Fee-for-service (FFS) - The general payment method HRSA uses to reimburse for covered family planning medical services provided to clients.

Health and Recovery Services Administration (HRSA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI State Children's Health Insurance Program (SCHIP), Title XVI Supplemental Security Income for the Aged, Blind, and Disabled (SSI), and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Informed consent - When an individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

- Disclosed and discussed the client's diagnosis;
- Offered the client an opportunity to ask questions about the procedure and to request information in writing;
- Given the client a copy of the consent form;
- Communicated effectively using any language interpretation or special communication device necessary per 42 CFR 441.257; and
- Given the client oral information about all of the following:
 - √ The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure;
 - √ Alternatives to the procedure including potential risks, benefits, and consequences; and
 - √ The procedure itself, including potential risks, benefits, and consequences.

Intensive Follow-up Services (IFS) - Those supplemental services specified in some TAKE CHARGE provider contracts that support clients in the successful use of contraceptive methods. DSHS-selected TAKE CHARGE providers perform IFS as part of the research component of the TAKE CHARGE program. [WAC 388-532-710]

HRSA-Approved Family Planning Provider -

A physician, advanced registered nurse practitioner (ARNP), or clinic that has:

- Agreed to the requirements of WAC 388-532-110;
- Signed a Core Provider Agreement with HRSA;
- Assigned a unique family planning provider number by HRSA; and
- Signed a special agreement that allows the provider to bill for family planning laboratory services provided to clients enrolled in an HRSA managed care plan through an independent laboratory certified through the Clinical Laboratory Improvements Act (CLIA). [WAC 388-532-050]

Managed care – A comprehensive health care delivery system that includes preventive, primary, specialty, and ancillary services. These services are provided through either a managed care organization (MCO) or Primary Care Case Management (PCCM) provider. [WAC 388-538-050]

Maximum allowable - The maximum dollar amount HRSA reimburses a provider for specific services, supplies, and equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy and Medically Needy programs.

Medical Identification (ID) card - The document DSHS uses to identify a client's eligibility for a medical program.

Medical chart - A written summary (kept by the provider) of the nursing or medical care rendered to an individual patient.

Medically necessary - A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, 'course of treatment' may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

Natural family planning - Also known as fertility awareness method, means methods such as observing, recording, and interpreting the natural signs and symptoms associated with the menstrual cycle in order to identify the fertile days of the menstrual cycle and avoid unintended pregnancies. [WAC 388-532-050]

Over-the-Counter (OTC) – Drugs that do not require a prescription before they can be sold or dispensed. [WAC 388-530-1050]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medical Assistance client and which consists of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Primary Care Provider (PCP) - A person licensed or certified under Title 18 RCW including, but not limited to, a physician or advanced registered nurse practitioner (ARNP) who supervises, coordinates, and provides health services to a client or an enrollee, initiates referrals for specialists and ancillary care, and maintains the client's or enrollee's continuity of care.

Provider or provider of service – An institution, agency, or person:

- Who has a signed agreement (Core Provider Agreement) with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department.

Remittance and Status Report (RA) - A report produced by HRSA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Retroactive period - The three calendar months before the month of application. [WAC 388-500-0005]

Revised Code of Washington (RCW) - Washington State laws.

State Children's Health Insurance Program (SCHIP)

Sexually Transmitted Disease-Infection (STD-I) – Is a disease or infection acquired as a result of sexual contact. [WAC 388-532-050]

TAKE CHARGE - HRSA's five-year demonstration and research program approved by the federal government under a Medicaid program waiver to provide family planning services. [WAC 388-532-710]

TAKE CHARGE Provider - A provider who is approved by HRSA to participate in TAKE CHARGE by:

- Being an approved HRSA family planning provider; and
- Having a supplemental TAKE CHARGE agreement to provide TAKE CHARGE family planning services to eligible clients under the terms of the federally-approved Medicaid waiver for the TAKE CHARGE program.
[WAC 388-532-710]

Third-Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client.
[WAC 388-500-0005]

Title XIX - The portion of the Federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.
[WAC 388-500-0005]

Usual and Customary Fee - The amount providers bill the Department for a certain service or equipment. This amount may not exceed:

- The usual and customary charge billed to the general public for the same services; or
- If the general public is not served, the amount normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

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Reproductive Health Services

How does HRSA define reproductive health services?

[WAC 388-532-001]

HRSA defines reproductive health services as those services that:

- Assist clients to avoid illness, disease, and disability related to reproductive health;
- Provide related and appropriate, medically-necessary care when needed; and
- Assist clients to make informed decisions about using medically safe and effective methods of family planning.

Provider Requirements [Refer to WAC 388-532-110]

To be paid by HRSA for reproductive health services provided to eligible clients, physicians, advanced registered nurse practitioners (ARNPs), licensed midwives, and HRSA-Approved Family Planning Providers must:

- Meet the requirements in [Chapter 388-502 WAC Administration of Medical Programs - Providers](#);
- Provide only those services that are within the scope of their licenses;
- Educate clients on Food and Drug Administration (FDA)-approved prescription birth control methods and over-the-counter (OTC) birth control supplies and related medical services;
- Provide medical services related to FDA-approved prescription birth control methods and OTC birth control supplies upon request; and
- Supply or prescribe FDA-approved prescription birth control methods and OTC birth control supplies upon request.

Note: Providers who are unable to meet all of the requirements above must refer the client to an appropriate provider.

Who is eligible? [Refer to WAC 388-532-100(1)]

HRSA covers limited, medically necessary reproductive health services for clients presenting DSHS Medical Identification (ID) cards with one of the following identifiers:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP - CHIP	CNP – Children’s Health Insurance Program
GAU No Out of State Care	General Assistance Unemployable
General Assistance	ADATSA
LCP-MNP	Limited Casualty Program-Medically Needy Program

Note: Family Planning Only and TAKE CHARGE clients are **only** eligible to receive services that are related to preventing unintended pregnancy and are **not** eligible for other reproductive health services.

Limited Coverage:

- HRSA covers reproductive health services under Emergency Medical Only programs **only** when the services are directly related to an emergency medical condition.
- HRSA pays only Medicare premium copays, coinsurance, and deductibles for Qualified Medicare Beneficiary clients.

What reproductive health services may an HRSA managed care client receive outside of the client's plan?

[Refer to WAC 388-532-100(2)]

Clients enrolled in an HRSA managed care plan may **self-refer** outside their plan for family planning*, abortions, and sexually transmitted disease-infection (STD-I) services to any of the following:

- An HRSA-Approved Family Planning Provider; or
- An HRSA-contracted local health department/STD-I clinic; or
- An HRSA-contracted provider who provides abortions; or
- An HRSA-contracted pharmacy (see HRSA's *Prescription Drug Program Billing Instructions*) for:
 - √ Over-the-counter contraceptive supplies; and
 - √ Contraceptives and STD-I related prescriptions from an HRSA-Approved Family Planning Provider or HRSA contracting local health department/STD-I clinic.

* *Excludes sterilizations for clients 21 years of age or older.*

[WAC 388-532-140](2)

When a client enrolled in a department-approved managed care plan self-refers outside the plan to either a department approved family planning provider or a department-contracted local health department STD-I services, all laboratory services must be billed through the family planning provider. When a client enrolled in a department managed care plan obtains family planning or STD-I services from a department-approved family planning provider or a department-contracted local health department STD-I clinic which has a contract with the managed care plan, those services **must** be billed directly to the managed care plan.

What services are covered? [Refer to WAC 388-532-120]

Services for Women

In addition to the reproductive health services listed in HRSA's *Physician-Related Services Billing Instructions*, HRSA covers the following reproductive health services:

- **Cervical, vaginal, and breast cancer screening examination**, once per year as medically necessary. The examination must be:
 - √ Provided according to the current standard of care; and
 - √ Conducted at the time of an office visit with a focused medical problem (contraceptive intervention/management and/or a medical intervention).

Note: HRSA does not pay for preventive health exams for clients 21 years of age and older. A gynecological exam performed without a problem-focused need is not a covered service.

- **FDA-approved prescription contraception method**
(see HRSA's *Prescription Drug Program Billing Instructions*);
- **OTC contraceptives, drugs, and supplies**
(see HRSA's *Prescription Drug Program Billing Instructions*);
- **Maternity-related services;**
(see HRSA's *Physician-Related Services Billing Instructions*)
- **Abortions;**
(see HRSA's *Physician-Related Services Billing Instructions*)
- **Sterilization** procedures that meet the requirements of HRSA's *Physician-Related Services Billing Instructions*, if it is:
 - √ Requested by the client; and
 - √ Performed in an appropriate setting for the procedure.

Note: The surgeon's initial office visit for sterilization is covered when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days prior to the surgery.

Services for Women (continued)

- **Screening and treatment for STD-I**, including laboratory tests and procedures;
 - √ HIV testing use CPT 86703.
- **Education and supplies** for FDA-approved contraceptives, natural family planning, and abstinence;
- **Mammograms** for clients 40 years of age and older, once per year
- **Colposcopy** and related medically necessary follow-up services.

Note: HIV testing and counseling is not a covered service for TAKE CHARGE and Family Planning Only clients.

Services for Men

In addition to the reproductive health services listed in HRSA's *Physician-Related Services Billing Instructions*, HRSA covers the following reproductive health services for men:

- **Office visits** where the primary focus and diagnosis is contraceptive management (including condoms and vasectomy counseling) and/or there is a medical concern;
- **OTC contraceptives, drugs, and supplies** (as described in HRSA's *Prescription Drug Program Billing Instructions*);
- **Sterilization** procedures that meet the requirements of HRSA's *Physician-Related Services Billing Instructions*, if they are:
 - √ Requested by the client; and
 - √ Performed in an appropriate setting for the procedure.

Note: The surgeon's initial office visit for sterilization is covered when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days prior to the surgery.

- **Screening and treatment for STD-I**, including laboratory tests and procedures;
 - √ HIV testing use CPT 86703.

Services for Men (continued)

- **Education and supplies** for FDA-approved contraceptives, natural family planning, and abstinence; and
- **Prostate cancer screening** for men who are 50 years of age and older, once per year. See Billing section, page E.5 for billing specifics.

What services are not covered? [Refer to WAC 388-532-130]

HRSA does not cover the reproductive health services listed as noncovered in HRSA's *Physician-Related Billing Instructions*. HRSA reviews requests for noncovered services according to WAC 388-501-0160.

Note: HRSA does not pay for preventive health exams for clients 21 years of age and older.

Reimbursement

[Refer to WAC 388-532-140, WAC 388-530-1425, and WAC 530-1700(4)]

Fee Schedule: HRSA reimburses providers for covered reproductive health services using the fee schedule contained in HRSA's *Physician-Related Services Billing Instructions*. (To view billing instructions, go to: <http://maa.dshs.wa.gov/> and select Billing Instructions/ Numbered Memoranda.)

Department-Approved Family Planning Clinics that Dispense

Contraception: Must comply with WAC 388-530-1700(4) Pharmacy Services.

- **For services:** Bill HRSA your *usual and customary fee* (the fee you bill the general public). HRSA's payment will be either your usual and customary fee or HRSA's maximum allowable rate, whichever is less.
- **For drugs purchased under the Public Health Services Act:** Providers must meet the criteria in WAC 388-530-1425.
- **For other contraceptives, drugs, drug supplies and devices, not purchased under the Public Health Services Act.** For those drugs or items with a maximum allowable fee, the maximum allowable fee approximates the clinic's estimated acquisition costs. Bill HRSA your *usual and customary fee* (the fee you bill the general public). HRSA's payments will be either your usual and customary fee or HRSA's maximum allowable fee, whichever is less.

HRSA-Approved Family Planning Providers

- If the fee schedule lists a drug or item as “acquisition cost”, you must bill your *actual acquisition cost* or certified full fee – not your usual and customary fee.

Managed Care: For clients who are enrolled in an HRSA managed care plan and self-refer to an HRSA-Approved Family Planning Provider or HRSA-contracted local health department/STD-I clinic outside their plan, all laboratory services must be billed through the family planning provider.

Note: Only the provider who rendered the services is allowed to bill for those services except in the case where a client self-refers outside of Managed Care for Family Planning services.

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Family Planning Only Program

What is the purpose of the Family Planning Only program?

[Refer to WAC 388-532-500]

The purpose of the Family Planning Only program is to provide family planning services at the end of a pregnancy to women who received medical assistance benefits during their pregnancy.

The primary goal of the Family Planning Only program is to prevent an unintended subsequent pregnancy. Women receive this benefit automatically regardless of how or when the pregnancy ends. This 10-month benefit follows the 60-day postpregnancy coverage by HRSA. **Men are not eligible for the Family Planning Only program.**

When the pregnant woman applies for medical assistance, the Community Services Office (CSO) worker identifies the woman's expected date of delivery. At the end of the 60-day postpartum period, the woman automatically receives an informational flyer and a Medical ID card stating *FAMILY PLANNING ONLY*. If her pregnancy ends for any reason other than delivery, she **must** notify the CSO to receive the Family Planning Only Medical ID card.

Provider Requirements [Refer to WAC 388-532-520]

To be paid by HRSA for services provided to clients eligible for the Family Planning Only program, physicians, advanced registered nurse practitioners (ARNPs), and HRSA-Approved Family Planning Providers must:

- Meet the requirements in Chapter 388-502 WAC, *Administration of Medical Programs - Provider* rules;
- Provide only those services that are within the scope of their licenses;
- Educate clients on Food and Drug Administration (FDA)-approved prescription birth control methods and over-the-counter (OTC) birth control supplies and related medical services;
- Provide medical services related to FDA-approved prescription birth control methods and OTC birth control supplies upon request; and
- Supply or prescribe FDA-approved prescription birth control methods and OTC birth control supplies upon request.

Note: Providers who are unable to meet all of the provider requirements must refer the client to an appropriate provider.

Who is eligible? [WAC 388-532-510]

A woman is eligible for Family Planning Only services if:

- She received medical assistance benefits during her pregnancy; or
- She is determined eligible for a retroactive period (see [Definitions](#) section) covering the end of the pregnancy.

What services are covered? [Refer to WAC 388-532-530]

Note: All services provided to Family Planning Only clients must have a primary focus and diagnosis of family planning (the ICD-9-CM V25 series diagnosis codes, excluding V25.3).

HRSA covers the following services under the Family Planning Only program:

- **Cervical, vaginal, and breast cancer screening examination**, once per year as medically necessary. The examination must be:
 - √ Provided according to the current standard of care; and
 - √ Conducted at the time of an office visit with a primary focus and diagnosis of family planning (ICD-9-CM V25 series diagnosis codes, excluding V25.3).
- **FDA-approved prescription contraception methods**
(see HRSA's *Prescription Drug Program Billing Instructions* for requirements)
- **OTC contraceptives, drugs, and supplies**
(see HRSA's *Prescription Drug Program Billing Instructions*)
- **Sterilization** procedures that meet the requirements of HRSA's *Physician-Related Services Billing Instructions*, if it is:
 - √ Requested by the client; and
 - √ Performed in an appropriate setting for the procedure.

Note: The surgeon's initial office visit for sterilization is covered when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days prior to the surgery.

(Continued on next page)

HRSA-Approved Family Planning Providers

- **Screening and treatment for STD-I**, including laboratory tests and procedures only when the screening and treatment is:
 - √ Performed in conjunction with an office visit that has a primary focus and diagnosis of family planning (the ICD-9-CM V25 series diagnosis codes, excluding V25.3); and
 - √ Medically necessary for the client to safely, effectively, and successfully use, or continue to use, her chosen contraceptive method.
- **Education and supplies** for FDA-approved contraceptives, natural family planning, and abstinence.

What drugs and supplies are reimbursed under the Family Planning Only program?

HRSA reimburses for the family planning related drugs and contraceptives within the following therapeutic classifications:

Contraceptives that can be dispensed from a HRSA-approved Family Planning clinic.	Contraceptives that can only be dispensed from a pharmacy.
Oral contraceptives Contraceptives, injectables Contraceptives, transdermal Contraceptives, intravaginal Contraceptives, intravaginal, systemic Vaginal lubricant preparations Condoms Diaphragms/cervical caps Intrauterine devices	Oral contraceptives Contraceptives, injectables Contraceptives, transdermal Contraceptives, intravaginal Contraceptives, intravaginal, systemic Vaginal lubricant preparations Condoms Diaphragms/cervical caps Intrauterine devices Vaginal antifungals Vaginal Sulfonamides Vaginal Antibiotics Tetracyclines Macrolides Antibiotics, misc. other Quinolones Cephalosporins – 1st generation Cephalosporins – 2nd generation Cephalosporins – 3rd generation Absorbable Sulfonamides Nitrofurantoin Derivatives Antifungal Antibiotics Antifungal Agents Anaerobic antiprotozoal – antibacterial agents
	* Antianxiety Medication – Before Sterilization Procedure Diazepam Alprazolam
	* Pain Medication – After Sterilization Procedure Acetaminophen with Codeine #3 Hydrocodone Bitartrate/Acetaminophen Oxycodone HCl/Acetaminophen 5/500 Oxycodone HCl/Acetaminophen

* Selected drugs are copied from Numbered Memorandum [05-05](#) HRSA.

HRSA-Approved Family Planning Providers

Over-the-counter, non-prescribed contraceptive supplies (e.g., condoms, spermicidal foam, cream, gel, sponge, etc.,) may also be obtained in a 30-day supply through a pharmacy with a Medical ID card.

Contraceptive hormone prescriptions must be written for three or more months, with a maximum of 12 months, unless there is a clinical reason to write the prescription for less than three months.

Note: All services provided to Family Planning Only clients **must** have a primary focus and diagnosis of family planning (the ICD-9-CM V25 series diagnosis codes, excluding V25.3).

What services are *not* covered? [WAC 388-532-540]

Medical services are not covered under the Family Planning Only program unless those services are:

- Performed in relation to a primary focus and diagnosis of family planning (ICD-9-CM V25 series diagnosis codes, excluding V25.3); and
- Medically necessary for the client to safely, effectively, and successfully use, or continue to use, their chosen contraceptive method.

Abortions are **not** covered under the Family Planning Only program.

Note: If the client's DSHS Medical ID card says *Family Planning Only* but she is pregnant, please refer the client to her local Community Services Office (CSO) to be evaluated for a possible change in her Medical Assistance program that would enable her to receive full scope of care.

Inpatient Services: HRSA does not pay for inpatient services under the Family Planning Only program. However, inpatient costs may be incurred as a result of complications arising from covered family planning services. If this happens, providers of inpatient services must submit a complete report to HRSA of the circumstances and conditions that caused the need for the inpatient services in order for HRSA to consider payment under WAC 388-501-0160.

A complete report includes:

- A copy of the billing (UB-92, HCFA-1500);
- Letter of explanation;
- Discharge summary; and
- Operative report (if applicable).

Fax the complete report to HRSA Division of Medical Management at (360) 586-1471.

Reimbursement

[Refer to WAC 388-532-550, WAC 388-530-1425, and WAC 530-1700(4)]

Fee Schedule: HRSA limits reimbursement under the Family Planning Only program to visits and services listed on the Fee Schedule (see section D) that:

- Have a primary focus and diagnosis of family planning as determined by a qualified, licensed medical practitioner (ICD-9-CM V25 series diagnosis codes); and
- Are medically necessary for the client to safely, effectively, and successfully use, or continue to use, their chosen contraceptive method.

Department-Approved Family Planning Clinics that Dispense

Contraception: Must comply with WAC 388-530-1700(4) Pharmacy Services.

- **For services:** Bill HRSA your *usual and customary fee* (the fee you bill the general public). HRSA's payment will be either your usual and customary fee or HRSA's maximum allowable rate, whichever is less.
- **For drugs purchased under the Public Health Services Act:** Providers must meet the criteria in WAC 388-530-1425.
- **For other contraceptives, drugs, drug supplies and devices, not purchased under the Public Health Services Act.** For those drugs or items with a maximum allowable fee, the maximum allowable fee approximates the clinic's estimated acquisition costs. Bill HRSA your *usual and customary fee* (the fee you bill the general public). HRSA's payments will be either your usual and customary fee or HRSA's maximum allowable fee, whichever is less.
- If the fee schedule lists a drug or item as "acquisition cost", you must bill your *actual acquisition cost* or certified full fee – not your usual and customary fee.

TAKE CHARGE Program

What is the purpose of TAKE CHARGE?

[Refer to WAC 388-532-700]

TAKE CHARGE is a family planning demonstration and research program. The purpose of the TAKE CHARGE program is to make family planning services available to men and women with incomes at or below 200 percent of the federal poverty level. TAKE CHARGE is approved by the federal government under a Medicaid program waiver.

Note: All medical ID cards dated 8/1/05 and after are valid until 6/30/06 unless the TAKE CHARGE program is extended.

The goal of TAKE CHARGE is to reduce unintended pregnancies by offering family planning services to an expanded population of low-income women and men.

TAKE CHARGE will increase access to family planning (birth control) services for persons for whom an unintended pregnancy might make it difficult to attain self-sufficiency and/or to remain self-sufficient.

The program objectives are to:

- Decrease the number of unintended pregnancies;
- Increase the use of contraception methods;
- Increase the availability of family planning services for low-income women and men;
- Raise the awareness of providers regarding the importance of client-centered education, counseling, and risk reduction to increase successful use of contraception methods; and
- Demonstrate through research that clients receiving intensive follow-up services (IFS) are more likely to be successful users of their chosen birth control method.

Note: A TAKE CHARGE client may only be seen by an HRSA-approved and trained TAKE CHARGE provider for family planning services. Exceptions to this include sterilizations, pharmacy services, and laboratory services. See pages C.5 for further information.

Program Information

The TAKE CHARGE and Family Planning Only program provide a narrow range of services for reproductive health care. Services provided under TAKE CHARGE and Family Planning Only program must be directly related to the goal of preventing unintended pregnancy.

The TAKE CHARGE and Family Planning Only program **do not** provide comprehensive reproductive health care. By providing family planning services to low income people, these two programs hope to improve the health of Washingtonians by reducing the physical, psychosocial, and financial burdens to individuals, families, communities that are related to unintended pregnancy.

Resource: For more information on the impacts of an unintended pregnancy, read “The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families”, 1995 Sara S. Brown and Leon Eisenberg.

The following aspects of reproductive health relate to preventing an unintended pregnancy: all methods of contraception, including reversible, permanent, and abstinence. The following reproductive health services have no relationship to the prevention of an unintended pregnancy: infertility treatment, prenatal care, and the treatment of breast, cervical, ovarian or testicular cancer.

Note: Pap smears are not directly related to the safe, effective and successful use of any contraceptive method. There have been recent changes to national guidelines. HRSA will cover pap smears (one per year) that fall under the new guidelines set by any of the following: the American College of Obstetrics and Gynecology, the American Cancer Society or the US Preventive Service Task Force.

The concern for many providers is the areas of reproductive health care that are not so clear cut. The gray areas where there is a direct relationship to contraception and unintended pregnancy. Using contraceptives safely, effectively and successfully can be complicated.

When determining what is covered under the TAKE CHARGE or Family Planning Only program, you must look at each client at the time of each visit and ask yourself, “How does his or her presenting issues and diagnosis at this visit relate to the safe, effective and successful use of his or her chosen contraceptive method?”

See illustration on page E.3: The services covered under the TAKE CHARGE and Family Planning Only program are part of reproductive health care (the target) but they must be directly related to preventing unintended pregnancy (the bull’s eye).

When a service falls into an area that feels gray or unclear to you, ask yourself how the services that you are providing are getting to the bulls eye. Detailed and thorough charting will be the justification. See page E.2 for clinic visits scenarios.

How do I qualify to be a TAKE CHARGE provider?

[Refer to WAC 388-532-730(1)(a) through (c)]

A TAKE CHARGE provider must:

- Be an HRSA-Approved Family Planning Provider (see the [Definitions](#) section);
- Sign the supplemental TAKE CHARGE agreement to participate in the TAKE CHARGE demonstration and research program according to HRSA's TAKE CHARGE program guidelines; and
- Participate in HRSA's specialized training for TAKE CHARGE prior to providing TAKE CHARGE services. Providers must also assure and have documentation that each individual responsible for providing TAKE CHARGE services is trained on all aspects of the TAKE CHARGE program.

What must I agree to before I am considered an approved TAKE CHARGE provider? [Refer to WAC 388-532-730(1)(d) and (e)]

TAKE CHARGE providers must comply with the required general HRSA and TAKE CHARGE provider policies, procedures, and administrative practices.

Administrative Practices

You must agree to provide:

- Service to eligible clients in accordance with state and federal law;
- Service to eligible clients in accordance with the TAKE CHARGE WAC 388-532-700 through 790;
- Annual client application assistance to screen for eligibility;
- TAKE CHARGE client files, billing, and medical records when requested by DSHS staff; and
- Referral information to clients regarding available and affordable non-family planning primary care services.

Evaluation and Research Responsibilities

If requested by HRSA, you must participate in the research and evaluation component of TAKE CHARGE. If selected by DSHS for the research and evaluation component, you must accept assignment to either:

- A randomly selected group of providers that give intensive follow-up service (IFS) to TAKE CHARGE clients under a TAKE CHARGE research component client services contract (most providers will fall into the “no research” group); or
- A randomly selected control group of providers subject to a TAKE CHARGE research component client services contract.

Services offered at the IFS or control group sites will be contracted and billed separately.

What policies and procedures do I need for confidentiality, consent, and release of information?

You must have policies and procedures that:

- Safeguard the confidentiality of clients’ records. These safeguards must:
 - √ Allow for timely sharing of information with appropriate professionals and agencies on the client’s behalf; **and**
 - √ Ensure that confidentiality of disseminated information is protected.
- Ensure you obtain all necessary and properly completed:
 - √ Consent forms for all sterilization procedures;
 - √ Authorization from clients for release of information related to this program; and
 - √ Informed consent as defined in WAC 388-531-0050 and as required by WAC 388-531-1550, as necessary.
- Ensure the proper release of client information:
 - √ To transfer information to another approved TAKE CHARGE provider when a client changes providers;
 - √ To transfer information to another approved TAKE CHARGE provider when you are unable to provide the service or unable to provide the service in a timely manner; and
 - √ To conform to all applicable state and federal laws.

√

When can providers who are not TAKE CHARGE providers furnish services for TAKE CHARGE clients?

[WAC 388-532-730(2)]

HRSA providers (e.g. pharmacies, laboratories, surgeons performing sterilization procedures) who are not TAKE CHARGE providers may furnish family planning ancillary services (see [Definitions](#) section) to eligible TAKE CHARGE clients.

HRSA reimburses for these services under the rules and fee schedules applicable to the specific services provided under HRSA's other programs.

Note: The partnership with pharmacists is especially critical since they provide immediate access to methods not received at the TAKE CHARGE agency/clinic.

Who is eligible? [WAC 388-532-720(1) and (2)]

The TAKE CHARGE program is for both men and women. To be eligible for the TAKE CHARGE program, an applicant must:

- Be a United States citizen, U.S. national, or qualified alien of the U.S.A. as described in chapter 388-424 WAC;
- Be a resident of the state of Washington as described in WAC 388-468-0005;
- Have income at or below 200% of the federal poverty level (FPL) as described in WAC 388-478-0075;
- Apply voluntarily for family planning services with a TAKE CHARGE provider; and
- Need family planning services but have no family planning coverage through another HRSA program or have health insurance that does not cover 100% of the client's chosen contraceptive method.

Note: A client who is currently pregnant or sterilized is not eligible for TAKE CHARGE.

How long can a client receive TAKE CHARGE coverage?

[WAC 388-532-720(3)]

A client is authorized for TAKE CHARGE coverage for one year from the date HRSA determines eligibility, or for the duration of the demonstration and research program, as long as the eligibility criteria continues to be met.

When a client reapplies for TAKE CHARGE, HRSA may renew the coverage for additional periods of up to one year each, or for the duration of the demonstration and research program, whichever is shorter.

Note:

- Always check Medical Eligibility Verification (MEV) to make sure that a client's one year eligibility for TAKE CHARGE is still valid or that they are not on another HRSA program that covers family planning.
- All Medical ID Cards dated 8/1/05 and after are valid until 6/30/06 unless the TAKE CHARGE program is extended.

How do I help a client apply for TAKE CHARGE?

Applicants must apply in person for TAKE CHARGE at an HRSA-approved TAKE CHARGE clinic or agency. Client eligibility is determined at the state level. **You, the provider**, must provide the applicant with:

Note: Applications must be completed at the provider's office.

- An application packet containing: a TAKE CHARGE Client Pre-Application Worksheet and a TAKE CHARGE Client Application form; and
- Application assistance in completing the documents prior to submitting the TAKE CHARGE Client Application to HRSA for eligibility determination.

Completed initial or recertification application must be entered into the TAKE CHARGE application database no later than 20 working days from the date of the client signature.

What is application assistance?

Application assistance is a reimbursable service for helping the client with the following actions in the following order:

1. Helping the applicant complete the required TAKE CHARGE Client Pre-Application Worksheet;
2. Reviewing the TAKE CHARGE Client Pre-Application Worksheet for completeness and accuracy. If it looks like the client does not meet eligibility requirements, **do not** proceed with the application process;
3. Helping the applicant complete the TAKE CHARGE Client Application (if you determined from the Client Pre-Application Worksheet that the applicant likely meets eligibility requirements);
4. Reviewing the TAKE CHARGE Client Application for completeness and accuracy;
5. Electronically submitting the completed TAKE CHARGE Client Application, no later than 20 working days from the date of the client signature, to the HRSA TAKE CHARGE Eligibility Unit for final eligibility determination (see page C.14); and
6. Retaining the TAKE CHARGE Client Pre-Application Worksheet and the TAKE CHARGE Client Application in the client's file.

Note: Billing for application assistance for clients transitioning from full scope Medicaid or Family Planning Only to TAKE CHARGE.

If a client has full scope Medicaid or Family Planning Only that is 30-60 days from expiring, they may apply for TAKE CHARGE before their other Medicaid coverage expires in order to have continuous contraceptive coverage. HRSA will pay the provider for application assistance in this situation. Contact either the TAKE CHARGE or the Family Planning program managers for specific details on payment.

EXAMPLE:

Susie Jones has full scope HRSA coverage that expires May 31st. She goes to a TAKE CHARGE provider on May 15th for a Deprovera shot. She can apply for TAKE CHARGE at this visit. The provider can bill for application assistance as well as the office visit and the injection. Providers may not bill for ECRR until the client has transitioned to TAKE CHARGE.

How do I check the TAKE CHARGE Client Pre-Application Worksheet?

Check the worksheet for accuracy, completeness, and potential eligibility.

Section I - Medical Need for Family Planning:

- The applicant states if he/she needs family planning. The applicant is **not** in need of family planning and **not** eligible for TAKE CHARGE if the applicant:
 - √ Has been sterilized;
 - √ Desires to be pregnant;
 - √ Does not plan to use birth control; or
 - √ Is pregnant.

Note: If the applicant meets any of these conditions, **do not proceed** with the application process.

Section II - Citizenship and Residency Requirements:

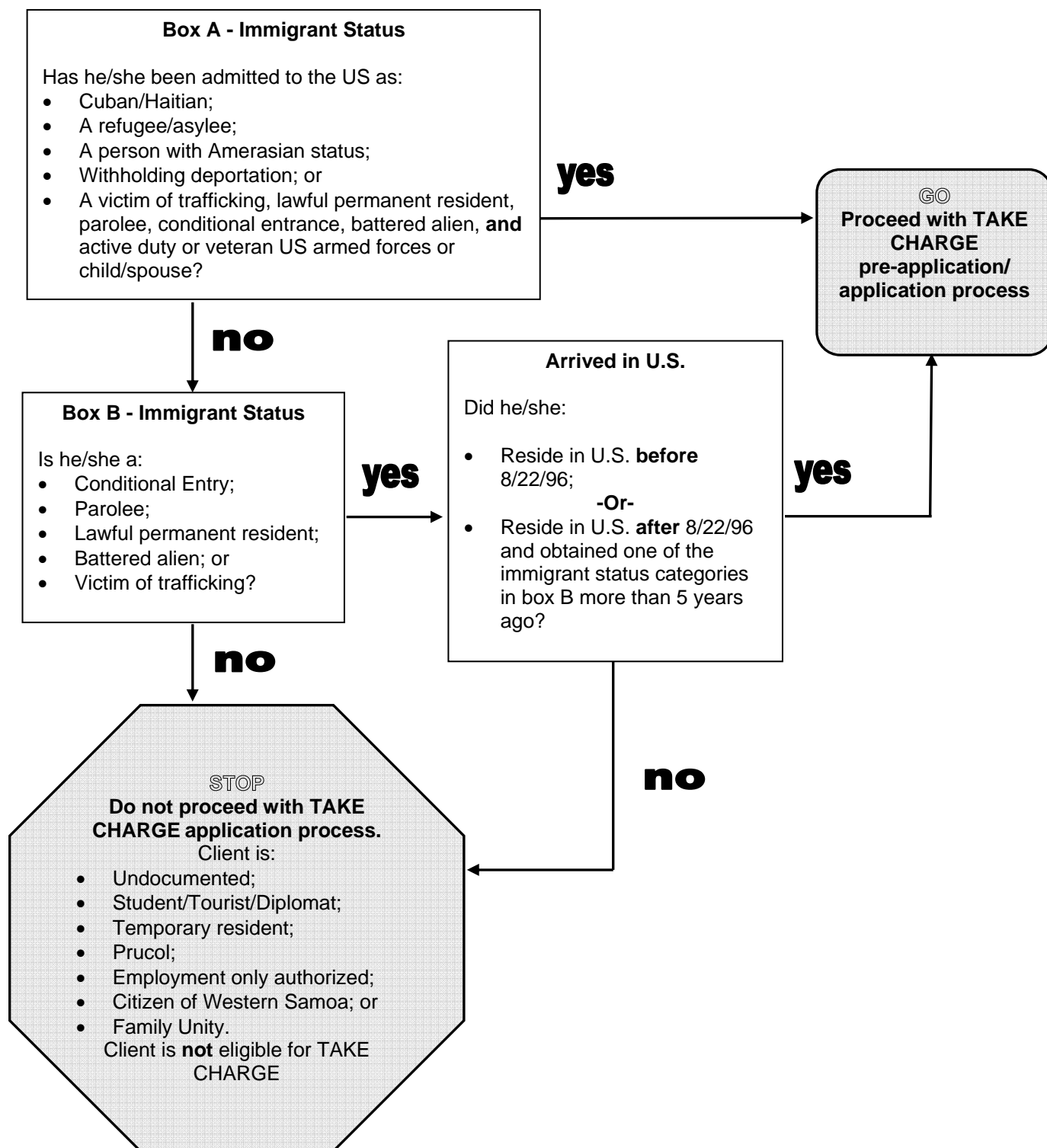
- The applicant for TAKE CHARGE services must reside in the state of Washington (e.g., not residing in Oregon or Idaho).
- Out-of-state college students who do not plan to remain in Washington when school is complete are not considered permanent Washington residents and do not qualify for TAKE CHARGE.
- The Code of Federal Regulations (CFR) states that students meet residency requirements if they:
 - √ Are attending college out-of-state;
 - √ Primarily reside in Washington; and
 - √ Intend to return to Washington.
- Foreign students or visiting foreign nationals are not considered permanent legal residents; they are only temporarily in Washington State and are not eligible for TAKE CHARGE.
- Illegal or undocumented persons are not eligible for TAKE CHARGE.
- Legal permanent residents must have had this status for 5 years to be eligible for TAKE CHARGE (except if the person arrived in the U.S. before August 22, 1996. See the **TAKE CHARGE Citizenship Criteria** flow chart, page C.10).

HRSA-Approved Family Planning Providers

- If the Department of Social and Health Services (DSHS) previously considered the applicant to be an illegal alien, and the applicant is now claiming legal status, documentation of legal status must be submitted with the TAKE CHARGE Client Application to the TAKE CHARGE Eligibility Unit.

If you have questions about determining the status of an applicant, telephone the TAKE CHARGE Eligibility Unit (see the *Important Contacts* section).

TAKE CHARGE Citizenship Criteria



Section III - Health Insurance:

- If the applicant has a DSHS Medical ID Card (is a current client of the department's program with Family Planning coverage), he/she is **not** eligible for TAKE CHARGE.
- If the applicant has health insurance, inform the applicant that their health insurance is billed first for TAKE CHARGE services. See [TAKE CHARGE Eligibility for Clients with Health Insurance](#) on page C.12.

Exceptions to billing Third-Party Insurance:

If an adolescent or a young adult is dependent on a parent/guardian's medical insurance and wishes to maintain confidentiality regarding his or her use of family planning services, check the "Young Adult" box; or

If a victim or a survivor of domestic violence has health insurance coverage and wishes to maintain confidentiality regarding his or her use of family planning services, consider that health insurance is not available to the client to prevent unintended pregnancy. Check the "Domestic Violence" box to avoid billing or other information being sent to the applicant's home address. See page E.8.

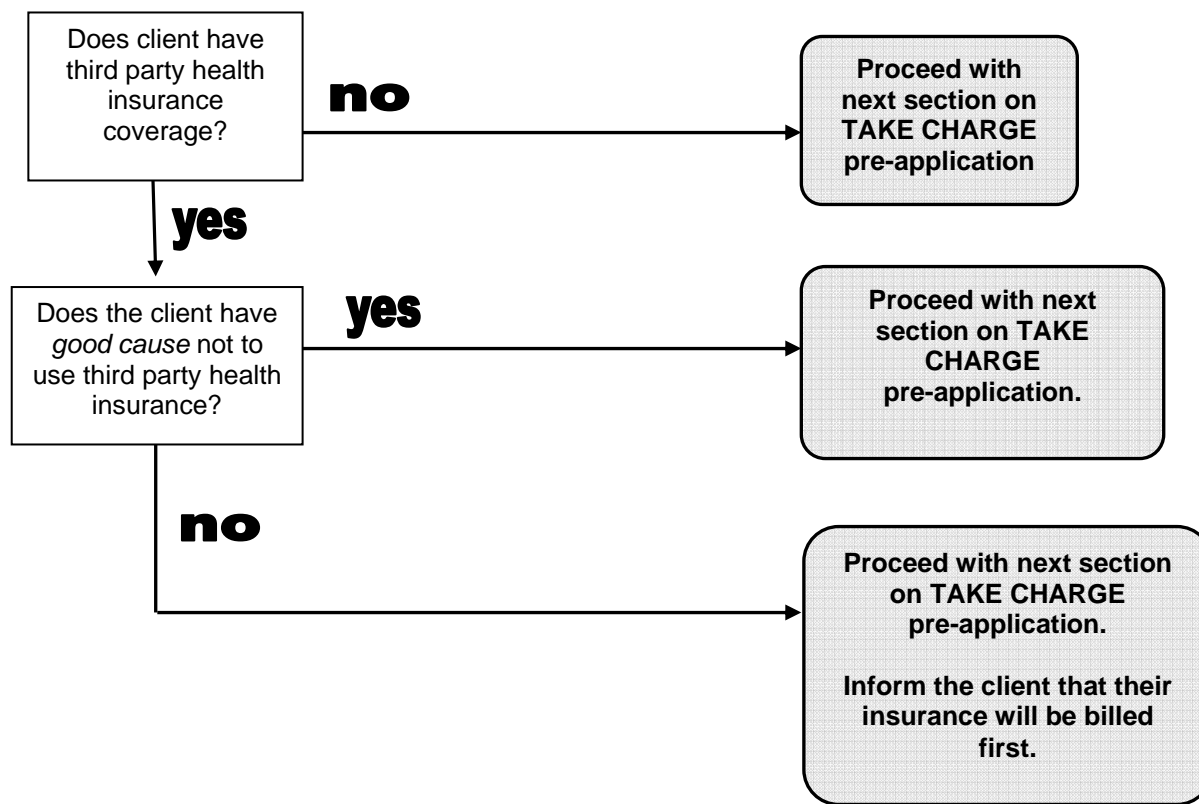
When you bill for Family Planning services for either exception above, do not indicate on the HCFA 1500 they have other insurance, in order to preserve confidentiality.

Note: If the client wishes to maintain confidentiality regarding the use of his or her family planning services, you must have some way of reaching the client.

Clients with health insurance, who are otherwise eligible, may apply for TAKE CHARGE, if their insurance does not cover 100% of their chosen contraceptive method.

Providers must bill the client's third-party insurance before billing the state for the unpaid balance of the claim.

TAKE CHARGE Eligibility for Clients with Health Insurance



Section IV - Income Requirements for Family Size:

Use the Federal Poverty Level (FPL) chart, revised annually each April, to determine whether the applicant meets the eligibility requirement of 200 percent of FPL or below. To view the Federal Health and Human Services listed Poverty level, visit:

http://www.dhs.state.ri.us/dhs/whatnew/pov_guidelines_05.pdf

US Dept Health & Human Services 2005 HHS Poverty Guidelines
<http://aspe.hhs.gov/poverty/05poverty.shtml>

Clients below 185% of the FPL, must make an appointment at their local CSO to see if they are eligible for a more comprehensive social service program. Do not sign them up for TAKE CHARGE if they could qualify for full scope Medicaid. If they are eligible for a more comprehensive social service program, this will supersede their TAKE CHARGE coverage and their Family Planning as well as other reproductive health needs will be covered by their comprehensive program.

Adolescents

- For adolescents seeking Family Planning services, whose parents know they are receiving/seeking these services, you must use the adolescents' income and the parents' income to determine income eligibility.
- For adolescents seeking confidential services and who do not want their parents to know about their need for Family Planning services, you may use the adolescents' self-disclosed income.

Complete Application

If, after reviewing the TAKE CHARGE Client Pre-Application Worksheet, there are no ineligibility indicators, have the applicant complete the TAKE CHARGE Client Application.

Do not Complete Application

If the applicant does not meet the requirements as outlined in the worksheet, **do not have the applicant complete a TAKE CHARGE Client Application.** You may choose to provide services to the person, but TAKE CHARGE will not pay you for those services.

How do I complete the TAKE CHARGE Application Process?

Review the information entered on the completed TAKE CHARGE Client Application for accuracy, completeness, and potential eligibility.

- Using the on-line database, submit only the TAKE CHARGE Client Application to the TAKE CHARGE Eligibility Unit (see the *Important Contacts* section). **Exception:** HRSA may make a special consideration for a provider who needs to submit client applications via fax.
- Completed initial or recertification application must be entered into the TAKE CHARGE application database no later than 20 business days from the date the client signs the application.
- You must keep the TAKE CHARGE Client Pre-Application Worksheet and the TAKE CHARGE Client Application in the client's file.
- A valid SSN is required for all TAKE CHARGE applicants, who are 18 years and older. Beginning April 3, 2006, you will not be able to enter a TAKE CHARGE application online without a valid SSN.

Exception: Adolescents 17 years and younger, who do not want their parents to know they are receiving Family Planning services, are encouraged, but not required to provide an SSN.

Note: HRSA issues only one TAKE CHARGE Medical ID card per client, and this card is good for one year from the beginning of the month of eligibility. At the end of the eligibility year, the client may reapply for services. The client may reapply every year until the TAKE CHARGE program ends or the client is no longer eligible. If a client becomes enrolled in another HRSA program that covers family planning services, the client is **no longer eligible** for TAKE CHARGE.

Do not bill HRSA for application assistance, if any part of the application is incomplete.

Checking for TAKE CHARGE Eligibility

Once the provider enters the client's application into the TAKE CHARGE database, HRSA's TAKE CHARGE Eligibility Unit determines eligibility.

Checking the Status of a Client Application

The provider uses the TAKE CHARGE database to check the status of the client application. (**Note:** Eligibility status may take up to 20 days to appear in the database). The database will indicate one of three things:

- ✓ Eligibility approved;
- ✓ Eligibility denied; or
- ✓ HRSA needs more information in order to complete the eligibility determination (this will be indicated by a note in comment box).

Eligibility Approved

If HRSA approves eligibility, the client will receive a TAKE CHARGE Medical Identification card in the mail, along with a TAKE CHARGE brochure.

In some instances, HRSA mails the TAKE CHARGE Medical ID card to the provider instead of the client. In this instance, make a copy of the card for the client's chart and **forward the Medical ID card and brochure to the client within 7 business days** unless the client has confidentiality reasons (see note, below). This ensures that the client has easy and immediate access to the TAKE CHARGE provider or pharmacy of his/her choice.

Note: If the client specifically requests, in writing, that the card **not** be forwarded to them for confidentiality reasons then the provider must document this in the pre-application and chart notes.

Eligibility Denied

If HRSA denies eligibility, the provider must inform the client of the eligibility denial.

Application Needs More Information

If there is a note in the application comment box requesting more information, the provider **must** obtain the requested information from the client and send it to the HRSA TAKE CHARGE Eligibility unit. The application cannot be processed for final eligibility determination until necessary information is obtained or the CSO records are changed to accurately reflect client information.

If you have questions regarding the department's comments/questions, in the comment box, please call the Eligibility Unit at 1- 877-787-2119.

What services are covered? [Refer to WAC 388-532-740]

Note: The purpose of the TAKE CHARGE program is to prevent unintended pregnancies. **All services provided under TAKE CHARGE must be related to the prevention of unintended pregnancy.**

HRSA covers the following TAKE CHARGE services for men and women:

- One session of **application assistance** per client, per year;
- **Food and Drug Administration (FDA)-approved prescription and nonprescription contraceptives** as provided in Chapter 388-530 WAC, including, but not limited to, the following:
 - √ Birth control pills;
 - √ Cervical cap;
 - √ Injectable contraceptives (Depo-Provera);
 - √ Diaphragm;
 - √ Emergency contraception;
 - √ Intrauterine devices (IUDs);
 - √ Birth control patch;
 - √ Birth control ring;
 - √ Spermicides (foam, gel, suppositories, sponges and cream); and
 - √ Male and female condoms.
- **Gynecological exam** which may include a cervical or vaginal cancer screening, pelvic and clinical breast examination, **one per year** when it is:
 - √ Provided according to the current standard of care; and
 - √ Conducted at the time of an office visit with a primary focus and diagnosis of family planning (ICD-9-CM V25 series diagnosis codes, excluding V25.3);
- **Education, counseling and risk reduction (ECRR) intervention** (see page C.18 *Education, Counseling, and Risk Reduction [ECRR] Services*) specifically intended for clients at higher risk of contraceptive failure, that have identified or demonstrated risks of unintended pregnancy.
- **Sterilization procedures** that meet the requirements found in these billing instructions and HRSA's *Physician-Related Services Billing Instructions*, if the service is:
 - √ Requested by the TAKE CHARGE client; and
 - √ Performed in an appropriate setting for the procedure;

(See **Note** on next page)

HRSA-Approved Family Planning Providers

Note: The surgeon's initial office visit for sterilization is covered, if performed more than one day prior to the surgery, when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days prior to the surgery.

- **Screening and treatment for STD-I**, including laboratory tests and procedures only when the screening and treatment is:
 - √ Performed in conjunction with an office visit that has a primary focus and diagnosis of family planning (the ICD-9-CM V25 series diagnosis codes, excluding V25.3); and
 - √ Medically necessary for the client to safely, effectively, and successfully use, or continue to use, his or her chosen contraceptive method.
- **Education and supplies** for FDA-approved contraceptives, natural family planning, and abstinence.

HRSA covers intensive follow-up services (IFS) for certain clients as part of the research component of the TAKE CHARGE program. Only those clients serviced by HRSA's randomly selected research sites receive IFS (see page C.4). The specific elements of IFS are negotiated with each research site.

Education, Counseling, and Risk Reduction (ECRR) Services

TAKE CHARGE providers must offer ECRR to eligible clients who have a demonstrated risk of unintended pregnancy. The cornerstone of the TAKE CHARGE program is education and counseling services designed to strengthen decision-making skills and support client's successful use of their chosen contraceptive method.

The department pays for an ECRR intervention service 30 minutes or more in duration. Effective for dates of service on and after February 1, 2006, if providers bill for ECRR, the service must be 30 minutes or more in duration.

Process:

The ECRR Model is a research-based, client-centered intervention or process that a TAKE CHARGE provider facilitates with the client. To succeed, this intervention requires building trust and rapport with the client. The intervention should focus on listening to the client. During ECRR the provider:

1. Asks a series of open ended questions.
2. Listens for client information, choices, needs, and risk factors; and
3. Offers client-focused information.

Service Delivery Parameters

1. For clients with identified or demonstrated risks of unintended pregnancy. **A client with a stable and successful contraceptive history is not eligible for ECRR;**
2. For women at risk of unintended pregnancy, limited to one ECRR service delivery every 10 months;
3. For men whose sexual partner is at risk of unintended pregnancy, limited to one ECRR service every 12 months;
4. Must be a minimum of 30 minutes in duration;
5. Must be appropriate and individualized to the client's needs, age, language, cultural background, risk behaviors, sexual orientation, and psychosocial history;
6. Must be provided by one of the following TAKE CHARGE trained providers:
 - ✓ A physician;
 - ✓ Advanced Registered Nurse Practitioner (ARNP);
 - ✓ Registered Nurse;
 - ✓ Licensed Practical Nurse;
 - ✓ Physician Assistant; or
 - ✓ A trained and experienced health educator or medical assistant when used for assisting and augmenting the above listed clinicians.
7. Must be clearly documented in the client's chart with detailed information that would allow for a well-informed follow-up visit.

Components

Five critical components are a part of the ECRR intervention. Integrate these 5 components into the counseling process by following the client's lead. Each component may overlap with the other components, but by the close of the client/provider interaction, you must have addressed and documented all of the components.

<p>Component A: Help the client (male or female) critically evaluate which contraceptive method is most acceptable and which method he/she can most effectively use.</p> <ul style="list-style-type: none"> • Focus first on the client's choice of method; • Assess and clarify knowledge, assumptions, misinformation, and myths about their chosen method(s); • Describe method benefits, including non-contraceptive benefits; • Address potential side effects and health risks; • Provide written materials that are culturally sensitive, clear, relevant, and easy to understand; and • Provide a telephone number to call if he or she has questions.
<p>Component B: Assess and address other client personal considerations, risk factors, and behaviors that impact her/his use of contraception.</p> <p>At a minimum, assess the following:</p> <ul style="list-style-type: none"> • History of abuse; • Current exploitation or abuse; • Current living situation; • Need for confidentiality; and • Make community referrals as necessary (e.g., domestic violence shelters and hotlines, food bank, mental health, substance abuse, other primary care needs).
<p>Component C: Facilitate discussion of the male role in successful use of chosen contraceptive method, as appropriate (for himself or for his female partner).</p> <ul style="list-style-type: none"> • With both female and male clients, assess and address partner issues (e.g., attitudes about birth control methods and how much the partner will be involved); • Reinforce male involvement in pregnancy prevention; and • Discuss male's role in supporting a partner's use of an individual method, as appropriate.
<p>Component D: Facilitate the client's contingency planning (the "back-up method") regarding the client's use of contraception, including planning for emergency contraception.</p> <ul style="list-style-type: none"> • Address side effects of the client's chosen method, and make sure the client knows what to do if there are side effects; • Discuss back-up methods with the client; • Provide information about access to emergency contraception as it relates to errors or problems with the chosen method; and • Provide a telephone number for the client to call with questions or concerns.
<p>Component E: Schedule follow-up appointments for birth control evaluation at or before 3 months, or as appropriate for the method chosen.</p> <ul style="list-style-type: none"> • Address questions about method use and follow up appointment, as needed; • Reinforce positive contraceptive and other self-protective behaviors; and • Follow up on any community referrals, as necessary.

Determining if a client is at increased risk for unintended pregnancy

Clients can have just one factor in their life that can put them at increased risk for pregnancy, but most often risk factors occur in clusters. Below you will find a list (not all inclusive) of some of the factors as they relate to the separate ECRR components that would give you a clue that a client would likely need some in depth counseling and education to support the safe, effective and successful use of their chosen contraceptive method.

When you chart both the client's history and your counseling intervention, make sure that the chart is detailed and thorough. This will facilitate a more meaningful and effective follow up at the clients next visit, whether you see the client again or another provider sees the client.

Risk by ECRR Component

1. Method

At Risk	Not at Risk
<ul style="list-style-type: none"> • Ambivalent about using Birth Control • Ambivalent about having sex • Fearful/Concerned about side effects • Trouble reading/understanding written materials • No partner support • Pattern of no follow-through previous BCMS • Wants method that has contraindications (e.g., smoker wants pill) • Younger teens • Doesn't believe they can get pregnant (or get someone pregnant) • Ambivalent about preventing pregnancy 	<ul style="list-style-type: none"> • Has successful method wants to continue • Already knowledgeable and motivated • Easy access (teen clinic nearby or at school) • Easy to use • Goal oriented and will not let anything get in the way (e.g. college, business venture, etc.) • Confident; Self-assured • Fear driven

2. Partner

At Risk	Not at Risk
<ul style="list-style-type: none"> • Multiple partners • Lack of communication • Abusive partner • Drug-using partner • Controlling partner • Unsupportive/uninvolved partner • Apathetic • Partner not willing to help with cost 	<ul style="list-style-type: none"> • Involved partner/Interested • Supportive partner • Communicative partner • Monogamous or long term partner • Trustworthy • Responsible • Partner comes to appointment • Impotent • Information seeking • Partner uses consistent method • Offers financial support

3. Personal Considerations

At Risk

- Low literacy level/education level
- No control transportation
- Confidentiality of method
- Substance abuse
- Abusive relationship
- History of sexual abuse
- Relationship status (length, etc)
- Ability to meet basic needs
- Living conditions
- Low self esteem
- No life goals (goals for future)
- Apathetic about future
- Mental health issues
- Maturity level
- Age at first intercourse
- # times pregnant
- Cultural beliefs
- Negative peer pressure
- Family history of teen pregnancy

Not at Risk

- Stable living environment
- No negative history of abuse
- Determination/intent not to become pregnant
- Good support system
- Positive peer pressure

4. Back-up

At Risk

- Mental illness
- Developmental delays
- Substance abuse
- Transportation issues/other access issues
- Uncooperative partner
- Have to contraception in secret
- Personal/religious beliefs, re. EC
- Has misinformation
- Allergies
- Ambivalence re sex/contraception
- Assertive

Not at Risk

(Exact opposite of risk characteristics listed on the left.)

What drugs and supplies are reimbursed under the TAKE CHARGE Program?

HRSA reimburses for the family planning related drugs and contraceptives within the following therapeutic classifications:

Contraceptives that can be dispensed from a HRSA-approved Family Planning clinic.	Contraceptives that can only be dispensed from a pharmacy.
Oral contraceptives Contraceptives, injectables Contraceptives, transdermal Contraceptives, intravaginal Contraceptives, intravaginal, systemic Vaginal lubricant preparations Condoms Diaphragms/cervical caps Intrauterine devices	Oral contraceptives Contraceptives, injectables Contraceptives, transdermal Contraceptives, intravaginal Contraceptives, intravaginal, systemic Vaginal lubricant preparations Condoms Diaphragms/cervical caps Intrauterine devices Vaginal antifungals Vaginal Sulfonamides Vaginal Antibiotics Tetracyclines Macrolides Antibiotics, misc. other Quinolones Cephalosporins – 1st generation Cephalosporins – 2nd generation Cephalosporins – 3rd generation Absorbable Sulfonamides Nitrofurantoin Derivatives Antifungal Antibiotics Antifungal Agents Anaerobic antiprotozoal – antibacterial agents
	* Antianxiety Medication – Before Sterilization Procedure Diazepam Alprazolam
	* Pain Medication – After Sterilization Procedure Acetaminophen with Codeine #3 Hydrocodone Bitartrate/Acetaminophen Oxycodone HCl/Acetaminophen 5/500 Oxycodone HCl/Acetaminophen

* Selected drugs are copied from Numbered Memorandum [05-05](#) HRSA.

HRSA-Approved Family Planning Providers

Over-the-counter, non-prescribed contraceptive supplies (e.g., condoms, spermicidal foam, cream, gel, sponge, etc.,) may also be obtained in a 30-day supply through a pharmacy with a Medical ID card.

Contraceptive hormone prescriptions must be written for three or more months, with a maximum of 12 months, unless there is a clinical reason to write the prescription for less than three months.

Note: All services provided to TAKE CHARGE clients **must** have a primary focus and diagnosis of family planning (the ICD-9-CM V25 series diagnosis codes, excluding V25.3).

What services are *not* covered? [WAC 388-532-750]

HRSA does not cover medical services under the TAKE CHARGE program unless those services are:

- Performed in relation to a primary focus and diagnosis of family planning; and
- Medically necessary for the client to safely, effectively, and successfully use, or continue to use, his or her chosen contraceptive method.

Abortions are not covered under the TAKE CHARGE program.

Other pregnancy related services are not covered under the TAKE CHARGE program.

Note: The purpose of the TAKE CHARGE program is to prevent unintended pregnancies. **All services provided under TAKE CHARGE must be related to the prevention of unintended pregnancy.**

Inpatient Services: HRSA does not cover inpatient services under the TAKE CHARGE program. However, inpatient costs may be incurred as a result of complications arising from covered TAKE CHARGE services. If this happens, providers of TAKE CHARGE related inpatient services that are not otherwise covered by third parties or other medical assistance programs must submit to HRSA a complete report of the circumstances and conditions that caused the need for the inpatient services in order for HRSA to consider payment under WAC 388-501-0165. A complete report includes:

- √ A copy of the billing (UB-92, HCFA-1500);
- √ Letter of explanation;
- √ Discharge summary; and
- √ Operative report (if applicable).

Fax the complete report to HRSA Division of Medical Management at (360) 586-1471.

Reimbursement

[Refer to WAC 388-532-780, WAC 388-530-1425 and 530-1700(4)]

Fee Schedule: HRSA limits reimbursement under the TAKE CHARGE program to those services that:

- Have a primary focus and diagnosis of family planning as determined by a qualified licensed medical practitioner; and
- Are medically necessary for the client to safely and effectively and successfully use, or continue to use, their chosen contraceptive method.

Department-Approved Family Planning Clinics that Dispense

Contraception: Must comply with WAC 388-530-1700(4) Pharmacy Services.

- **For services:** Bill HRSA your *usual and customary fee* (the fee you bill the general public). HRSA's payment will be either your usual and customary fee or HRSA's maximum allowable rate, whichever is less.
- **For drugs purchased under the Public Health Services Act:** Providers must comply with Pharmacy Services specified in WAC 388-530-1425.
- **For other contraceptives, drugs, drug supplies and devices, not purchased under the Public Health Services Act.** For those drugs or items with a maximum allowable fee, the maximum allowable fee approximates the clinic's estimated acquisition costs. Bill HRSA your *usual and customary fee* (the fee you bill the general public). HRSA's payments will be either your usual and customary fee or HRSA's maximum allowable fee, whichever is less.
- If the fee schedule lists a drug or item as "acquisition cost", you must bill your *actual acquisition cost* or certified full fee – not your usual and customary fee.

Intensive Follow-Up Services: HRSA limits reimbursement for TAKE CHARGE intensive follow-up services (IFS) to those randomly selected research sites described on page 2 of Definitions. Intensive Follow-Up Services will end June 30, 2006.

FQHC/RHC: Federally qualified health centers (FQHCs), rural health centers (RHCs), and Indian health providers who choose to become TAKE CHARGE providers must bill HRSA for TAKE CHARGE services without regard to their special rates and fee schedules. HRSA does **not** reimburse FQHCs, RHCs, or Indian health providers under the encounter rate structure for TAKE CHARGE services.

Billing Timeline: HRSA requires TAKE CHARGE providers to meet the billing requirements of WAC 388-502-0150 (billing time limits). In addition, billing adjustments related to the TAKE CHARGE program must be completed no later than three years after the demonstration and research program terminates. HRSA will not accept any new billings or any billing adjustments that increase expenditures for the TAKE CHARGE demonstration and research program after the cut-off date in this subsection.

Inpatient Services: HRSA does not cover inpatient services under the TAKE CHARGE program. However, inpatient costs may be incurred as a result of complications arising from covered TAKE CHARGE services. If this happens, providers of TAKE CHARGE related inpatient services that are not otherwise covered by third parties or other medical assistance programs must submit to HRSA a complete report of the circumstances and conditions that caused the need for the inpatient services in order for HRSA to consider payment under WAC 388-501-0165. A complete report includes:

- √ A copy of the billing (UB-92, HCFA-1500);
- √ Letter of explanation;
- √ Discharge summary; and
- √ Operative report (if applicable).

Fax the complete report to HRSA Division of Medical Management at (360) 586-1471.

Third-Party Liability: HRSA requires a provider under WAC 388-501-0200 to seek timely reimbursement from a third party when a client has available third party resources. See page E.8 for exceptions to this requirement.

The HRSA-Approved Family Planning Provider Fee Schedule (previously found on pages D.1 – D.8) is now located in the appendix. To view or download the Fee Schedule, click [Appendix](#).

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Billing

What if a provider has more than one provider number?

When your agency has more than one provider number, the following table outlines which number to use for billing Family Planning Services for fee-for-service (FFS) clients and self-referred HRSA managed care enrollees.

Type of Service	Reproductive Health Services Clients	Family Planning Only Clients	TAKE CHARGE Clients	Self-Referred HRSA Managed Care Enrollees
Family Planning	Family Planning number or Medical number	Family Planning number or Medical number	Family Planning number	Family Planning number
Sexually Transmitted Disease (STD-I) <i>(limited coverage for Family Planning Only and TAKE CHARGE clients)</i>	Family Planning number or Medical number	Family Planning number or Medical number	Family Planning number	Family Planning number
Abortion	Medical number	Not covered	Not covered	Medical number
Other: menopause, preventive care, abnormal pap, precancerous conditions	Medical number	Not covered	Not covered	Refer client to Primary Care Provider

What must I consider when billing?

The purpose of the Family Planning Only and the TAKE CHARGE program is to prevent unintended pregnancies. All services provided under these programs must be related to the prevention of unintended pregnancy.

Documentation in the client's chart must reflect that the majority of the time was spent with the client with the focus of family planning (ICD-9-CM V25 series diagnosis codes – excluding V25.3). See next page for examples of clinic visit scenarios.

Note: Billing adjustments related to the TAKE CHARGE program must be completed no later than three years after the demonstration and research program terminates. HRSA will not accept any new billings or any billing adjustments that increase expenditures for the TAKE CHARGE demonstration and research program after the cut-off date in this subsection. [Refer to WAC 388-532-780(5)]

Clinic Visit Scenarios

Example A

Client A has chosen to use an IUD. It is the standard of practice to screen for GC and CT prior to IUD insertion. This STD screening (and treatment if necessary) **would be** covered under TAKE CHARGE as it is not medically safe to insert an IUD into an infected uterus.

Example B

Client B has been a client at your clinic for several years. She has been an inconsistent condom and oral contraceptive user and at high risk for unintended pregnancy. She decides to try the NuvaRing and has been using it safely, effectively and successfully for six months. She comes into the clinic with complaints of spotting and bleeding especially after intercourse and believes it is caused by the hormones in the ring. She wants to quit the ring and go back to condoms. She mentions something about her new boyfriend and how he won't be too happy about having to use condoms. You are concerned that the bleeding may be caused by Chlamydia/Gonorrhea and not her hormonal contraceptive AND that she will again be at risk for pregnancy with a method that she didn't previously use well. You test her for Chlamydia/Gonorrhea, treat her presumptively, explain the importance of her partner getting treated and tested as well, discuss the importance of condoms for STD prevention and continue her with the NuvaRing.

Her office visit, lab tests and treatment **would be** covered because your thorough charting makes the link to the safe, effective and successful use of her birth control method.

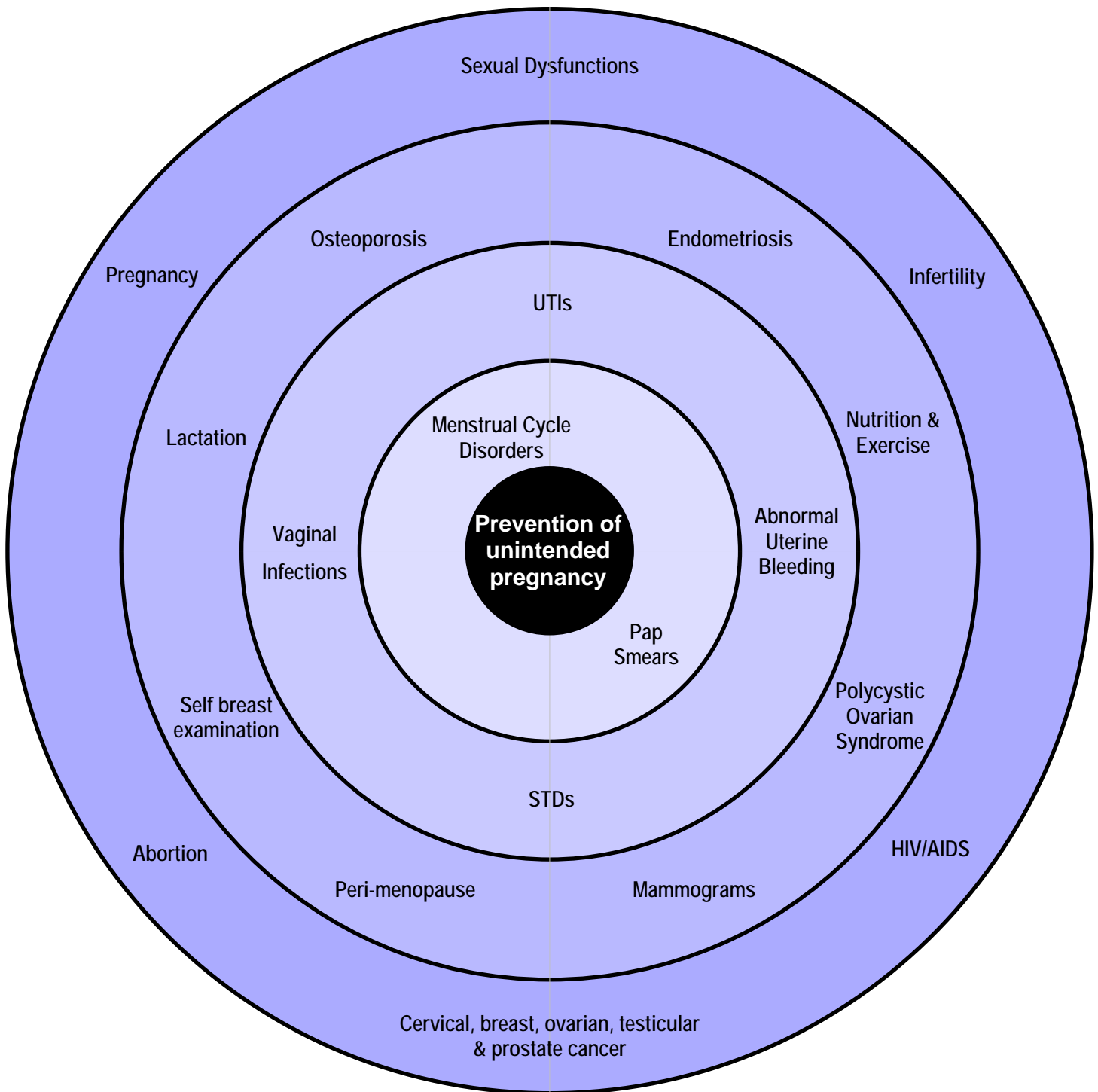
Example C

Client C comes into the clinic stating that she heard that her recent past partner "had something" and she wanted to be checked just to be sure. She is in a new relationship, using oral contraceptives and also using condoms for STD prevention. She is having no problems with her birth control method. She just wants to be screened for STD's. This visit would not be covered under TAKE CHARGE or Family Planning Only.

Example D

Client D was taken off of hormonal contraceptives when she was diagnosed with severe mononucleosis. She was jaundiced and her liver was enlarged during the acute phase of her illness. She is not happy using condoms, has had unprotected sex a couple of times and wants to resume her oral contraceptive use. You order lab work to determine that her liver function has returned to normal before restarting her on pills. This visit and labs tests would be covered under TAKE CHARGE and Family Planning Only. Again, your thorough charting of this clients history and current presenting issues will be your justification for requesting payment from HRSA for these services.

Aiming for the Bull's Eye Preventing Unintended Pregnancy



Frequently Asked Billing Questions

Does HRSA cover preventive medicine for routine annual physical examinations (CPT procedure codes 99384 – 99386 or 99394 – 99396) under Reproductive Health Services, the Family Planning Only program, and TAKE CHARGE?

No. Preventive medicine/routine physical exams are not covered for these procedure codes under Reproductive Health Services, the Family Planning Only program, or TAKE CHARGE.

Exception 1: Under Reproductive Health Services, clients 20 years of age and younger who have full scope Medicaid coverage are covered for certain physical examination procedure codes through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. For more information, refer to HRSA's *Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program Billing Instructions*.

Exception 2: For information on coverage for physical examinations for clients with developmental disabilities, refer to HRSA's *Physician-Related Services Billing Instructions*.

Does HRSA cover office visits for family planning counseling/contraception management under Reproductive Health Services, the Family Planning Only program, and TAKE CHARGE?

Office visits (CPT procedure codes 99201 – 99205 or 99211 – 99215) with a diagnosis code from the V25 series (excluding V25.3) are covered under Reproductive Health Services, Family Planning Only program, and TAKE CHARGE for family planning advice and contraceptive management.

Are routine pap smears and/or breast exams covered under Reproductive Health Services, the Family Planning Only program, and TAKE CHARGE?

A cervical or vaginal cancer screening pelvic exam and clinical breast exam are covered under Reproductive Health Services for procedure code G0101 with diagnosis code V76.2 (screen malignant neoplasm of cervix), V76.47 (screen malignant neoplasm of vagina), or V76.10 (breast screening unspecified).

A cervical or vaginal cancer screening pelvic exam and clinical breast exam are covered for Family Planning Only and TAKE CHARGE clients for procedure code G0101 with a diagnosis code from the V25 series (excluding V25.3).

If a client changes from TAKE CHARGE coverage to full scope Medicaid coverage, are they covered under the TAKE CHARGE program?

No, the client now is eligible for Reproductive Health Services, see Reproductive Health Services page B.1

Are prostate cancer screenings, digital rectal examinations, and prostate-specific antigen tests (PSA) covered under Reproductive Health Services, the Family Planning Only program, and TAKE CHARGE?

Prostate cancer screenings are covered under Reproductive Health Services with the following procedure codes and diagnoses:

- Males 50 years of age and older are covered for procedure code G0103 for prostate-specific antigen test (PSA) with diagnosis code V76.44 (special screening for malignant neoplasms prostate).
- Digital rectal exam (procedure code G0102) is bundled into the reimbursement for the office visit.

These prostate cancer screenings **are not** covered under the Family Planning Only program (which is for women only) or under TAKE CHARGE.

Are mammograms covered under Reproductive Health Services, the Family Planning Only program, and TAKE CHARGE?

Mammograms are covered for clients under Reproductive Health Services for women 40 years of age or older (one screening mammogram is covered annually).

Mammograms **are not** covered under the Family Planning Only program or TAKE CHARGE.

Are abortions covered under Reproductive Health Services, the Family Planning Only program, and TAKE CHARGE?

Abortions are covered for clients under Reproductive Health Services. Bill for these services with your medical number, not your family planning number. See page E.1.

Abortions **are not** covered under the Family Planning Only program or TAKE CHARGE.

Note: If a Family Planning Only or TAKE CHARGE client becomes pregnant, refer her to her local Community Services Office to see if she qualifies for medical services under another program.

What is the time limit for billing? [Refer to WAC 388-502-0150]

HRSA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. HRSA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

• Initial Claims

- √ HRSA requires providers to submit an **initial claim** to HRSA and obtain an ICN within 365 days from any of the following:
 - The date the provider furnishes the service to the eligible client;
 - The date a final fair hearing decision is entered that affects or has an impact on the particular claim;
 - The date a court orders HRSA to cover the services; or
 - The date DSHS certifies a client eligible under delayed¹ certification criteria.

Note: If HRSA has recouped a managed care plan's premium, causing the provider to bill HRSA, the billing time limit is 365 days from the date the plan recouped the payment from the provider.

- √ HRSA may grant exceptions to the 365 day time limit for initial claims when billing delays are caused by either of the following:
 - DSHS certification of a client for a retroactive² period; or

¹ **Delayed Certification** - According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

² **Retroactive Certification** - According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill HRSA for the service.

MAA-Approved Family Planning Providers

- The provider proves to HRSA's satisfaction that there are other extenuating circumstances.
 - √ HRSA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to HRSA's billing limits.
 - **Resubmitted Claims**
 - √ Providers may resubmit, modify, or adjust any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.
- Note:** HRSA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above. When rebilling, send a copy of the original Remittance and Status Report along with the claim. Be sure to cross out any lines that have already been paid.
- The time periods listed above do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to HRSA by claim adjustment. The provider must refund overpayments to HRSA by a negotiable financial instrument such as a bank check.
 - The provider, or any agent of the provider, **must not bill a client or a client's estate** when:
 - √ The provider fails to meet these listed requirements; and
 - √ HRSA does not pay the claim.

What fee should I bill HRSA for services?

Bill HRSA your *usual and customary fee* (the fee you bill the general public). HRSA's payment will be either your usual and customary fee or HRSA's maximum allowable rate, whichever is less.

When can I bill the client?

See HRSA's *General Information Booklet* or WAC 388-502-0160 for information on billing the client.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's DSHS Medical ID card. An insurance carrier's time limit for claim submissions may be different from HRSA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as HRSA's, prior to any payment by HRSA.

You must meet HRSA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claims are denied due to any existing third-party liability, refer to the corresponding HRSA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by HRSA, or if you have reason to believe that HRSA may make an additional payment:

- Submit a completed claim form to HRSA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the HRSA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on HRSA's web site at <http://maa.dshs.wa.gov/LTPR> or by calling the Coordination of Benefits Section at 1-800-562-6136.

Note: See the following for circumstances when TAKE CHARGE clients might have a *good cause* exception to billing third party insurance.

TAKE CHARGE Third Party Liability and *Good Cause*

[Refer to WAC 388-532-790]

The following TAKE CHARGE applicants may request an exemption of available third party coverage due to *good cause*:

- Adolescents or young adults seeking confidential services who depend on their parents' medical insurance; or
- Domestic violence victims.

Under the TAKE CHARGE program, *good cause* means that use of the third party coverage would violate his or her privacy because the third party:

- Routinely or randomly sends verification of services to the third party subscriber and that subscriber is other than the applicant; and/or
- Requires the applicant to use a primary care provider who is likely to report the applicant's request for family planning services to another party.

If either of these conditions apply, the applicant is considered for TAKE CHARGE without regard to the available third party family planning coverage.

Note: Clients must make this self-declaration on the TAKE CHARGE Pre-Application Worksheet in order to qualify for this exception.

What records must be kept? [Refer to WAC 388-502-0020]

All HRSA providers

Enrolled providers (including HRSA-Approved Family Planning Providers) must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:
 - √ Patient's name and date of birth;
 - √ Dates of service(s);
 - √ Name and title of person performing the service, if other than the billing practitioner;
 - √ Chief complaint or reason for each visit;
 - √ Pertinent medical history;
 - √ Pertinent findings on examination;
 - √ Medications, equipment, and/or supplies prescribed or provided;
 - √ Description of treatment (when applicable);
 - √ Recommendations for additional treatments, procedures, or consultations;
 - √ X-rays, tests, and results;
 - √ Plan of treatment and/or care, and outcome; and
 - √ Specific claims and payments received for services.
- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.
- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, **for at least six years from the date of service** or more if required by federal or state law or regulation.

TAKE CHARGE providers [Refer to WAC 388-532-760]

In addition to the documentation requirements listed previously, TAKE CHARGE providers must keep the following records:

- TAKE CHARGE Client Pre-Application worksheet form(s) and application(s);
- Chart notes that reflect that the primary focus and diagnosis of the visit was family planning;
- Contraceptive methods discussed with the client;
- Notes on any discussions of emergency contraception and needed prescription(s);
- The client's plan for the contraceptive method to be used, or the reason for no contraceptive method and plan;
- Documentation of the education, counseling and risk reduction (ECRR) service, if provided, including all of the required components found on page C.18-C.19;
- Documentation of referrals to or from other providers;
- A form signed by the client authorizing release of information for referral purposes, as necessary; and
- A copy of the completed Sterilization Consent Form, DSHS 13-364, as necessary (see page F.10 for how to obtain a copy of this form). For details about sterilization refer to HRSA's current *Physician-Related Services Billing Instructions*, or call Family Planning program manager (360) 725-1664. Click link to download the DSHS 13-364. http://www1.dshs.wa.gov/pdf/ms/forms/13_364a.pdf.
- Signed request from the client, asking that their Medical ID card should be sent to and held by the clinic, for confidentiality purposes.

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Sterilization

What is sterilization? [Refer to WAC 388-531-1550(1)]

Sterilization is any medical procedure, treatment, or operation for the purpose of rendering a client permanently incapable of reproducing. This includes vasectomies and tubal ligations.

Note: HRSA does **not** reimburse for hysterectomies performed solely for the purpose of sterilization. Refer to HRSA's *Physician-Related Services Billing Instructions* for information on hysterectomies.

What are HRSA's reimbursement requirements for sterilizations? [Refer to WAC 388-531-1550(2)]

HRSA covers sterilization when all of the following apply:

- The client has **voluntarily** given informed consent;
- The client is at least 18 years of age at the time consent is signed;
- The client is a mentally competent individual; and
- At least 30 days, but not more than 180 days, have passed between the date the client gave informed consent and the date of the sterilization.

Note: HRSA reimburses providers for sterilizations for managed care clients 18 through 20 years of age under the fee-for-service system. All other managed care clients must obtain their sterilization services from their managed care provider.

HRSA reimburses providers (e.g., hospitals, anesthesiologists, surgeons, and other attending providers) for a sterilization procedure only when the completed federally approved Sterilization Consent Form, DSHS 13-364, is attached to the claim. Click link to download the DSHS 13-364 http://www1.dshs.wa.gov/pdf/ms/forms/13_364a.pdf. HRSA does not accept any other forms attached to the claim. HRSA reimburses after the procedure is completed.

HRSA reimburses providers for epidural anesthesia in excess of the six-hour limit for deliveries if sterilization procedures are performed in conjunction with, or immediately following, a delivery. HRSA determines total billable units by:

- Adding the time for the sterilization procedure to the time for the delivery; and
- Determining the total billable units by adding together the delivery base anesthesia units (BAUs), the delivery time, and the sterilization time.

Do not bill the BAUs for the sterilization procedure separately.

Additional Requirements for Sterilization of Mentally Incompetent or Institutionalized Clients

Providers must meet the following additional consent requirements before HRSA will reimburse the provider for the sterilization of a mentally incompetent or institutionalized client. HRSA requires both of the following to be attached to the claim form:

- Court orders that include the following:
 - √ A statement that the client is to be sterilized; **and**
 - √ The name of the client's legal guardian, who will be giving consent for the sterilization.
- Sterilization Consent Form, DSHS 13-364, signed by the client's legal guardian.

When does HRSA waive the 30-day waiting period?

[WAC 388-531-1550(3) and (4)]

HRSA does not require the 30-day waiting period, but does require at least a 72 hour waiting period, for sterilization in the following circumstances:

- At the time of premature delivery, the client gave consent at least 30 days before the *expected* date of delivery. The expected date of delivery must be documented on the consent form.
- For emergency abdominal surgery, the nature of the emergency must be described on the consent form.

HRSA waives the 30-day consent waiting period for sterilization when the client requests that sterilization be performed at the time of delivery, **and** completes a Sterilization Consent Form, DSHS 13-364. One of the following circumstances must apply:

- The client became eligible for Medical Assistance during the last month of pregnancy (**HCFA 1500 field 19:** “*NOT ELIGIBLE 30 DAYS BEFORE DELIVERY*”); or
- The client did not obtain medical care until the last month of pregnancy (**HCFA 1500 field 19:** “*NO MEDICAL CARE 30 DAYS BEFORE DELIVERY*”); or
- The client was a substance abuser during pregnancy, but is not using alcohol or illegal drugs at the time of delivery. (**HCFA 1500 field 19:** “*NO SUBSTANCE ABUSE AT TIME OF DELIVERY.*”)

The provider must note on the HCFA-1500 claim form in field 19 or on the backup documentation, which of the above waiver condition(s) has been met. Required language is shown in parenthesis above. Providers who bill electronically, must indicate this information in the *Comments* field.

When does HRSA *not* accept a signed Sterilization Consent Form, DSHS 13-364? [Refer to WAC 388-531-1550(5) and (6)]

HRSA does not accept informed consent obtained when the client is in any of the following conditions:

- In labor or childbirth;
- Seeking to obtain or obtaining an abortion; or
- Under the influence of alcohol or other substances that affect the client’s state of awareness.

Why do I need a DSHS-approved Sterilization Consent Form?

Federal regulations prohibit payment for sterilization procedures until a federally approved and accurately completed Sterilization Consent Form, DSHS 13-364 is received. To comply with this requirement, surgeons, anesthesiologists, and assistant surgeons as well as the facility in which the surgery is being performed must obtain a copy of a completed Sterilization Consent Form, DSHS 13-364, to attach to their claim.

You must use Sterilization Consent Form, DSHS 13-364, in order for HRSA to pay your claim.
HRSA does not accept any other form.

To **download** DSHS forms, visit: <http://www1.dshs.wa.gov/msa/forms/eforms.html>
Scroll down to form number 13-364.

To **have a hard copy sent** to you, contact:
DSHS Forms Management Phone: (360) 664-6047 or Fax: (360) 664-6186

Include in your request:

- Form number and name;
- Quantity desired;
- Your name and your office name; and
- Your full mailing address.

HRSA will deny a claim for a procedure received without the Sterilization Consent Form, DSHS 13-364. HRSA will deny a claim with an incomplete or improperly completed Sterilization Consent Form. Submit the claim and completed Sterilization Consent Form, DSHS 13-364, to:

**HRSA Division of Program Support
PO Box 9248
Olympia WA 98507-9248**

If you are submitting your sterilization claim form electronically, be sure to indicate in the comments section that you are sending in a hard copy of the Sterilization Consent Form, DSHS 13-364. Then send in the form with the electronic claims ICN.

Who completes the Sterilization Consent Form, DSHS 13-364?

- Sections I, II, and III of the Sterilization Consent Form are completed by the client, interpreter (if needed), and the physician/clinic representative more than 30 days, but less than 180 days, prior to date of sterilization. If less than 30 days, refer to page F.2: "When does HRSA waive the 30 day waiting period?" and/or section IV of the Sterilization Consent Form.
- The bottom right portion (section IV) of the Sterilization Consent Form is completed shortly before, on, or after the surgery date by the physician who performed the surgery.

- If the initial Sterilization Consent Form sections I, II, and III are completed by one physician and a different physician performed the surgery:
 - ✓ Complete another Sterilization Consent Form entering the date it was completed; and
 - ✓ Submit both Sterilization Consent Form with your claim.

Frequently Asked Questions on Billing Sterilizations

Physician HCFA 1500 Claims

1. **If I provide sterilization services to TAKE CHARGE or Family Planning Only clients along with a secondary surgical intervention, such as lysis of adhesions, will I be paid?**

The scope of coverage for TAKE CHARGE and Family Planning Only clients is limited to contraceptive intervention only. HRSA does not pay for any other medical services unless they are medically necessary in order for the client to safely, effectively and successfully use or continue to use their chosen birth control method.

Only claims submitted with diagnosis codes in the V25 series (excluding V25.3) will be processed for possible payment. All other diagnosis codes are noncovered and will not be paid.

Note: Remember you must submit all sterilization claims with the **completed**, federally approved Sterilization Consent Form.

If I provide sterilization services to a Medicaid, full scope of care client along with a secondary surgical intervention, such as lysis of adhesions or C-Section delivery, how do I bill?

CNP clients have full scope of care and are eligible for more than contraceptive intervention only. Submit the claim with a completed, federally approved Sterilization Consent Form form for payment.

If you do not have the consent form or it wasn't completed properly or the client was sterilized prior to the 30 days waiting period (client doesn't meet the criteria for HRSA to waive the 30 day waiting period) then the sterilization line on the claim will be denied and the other line items on the claim will be processed for possible payment.

2. **How will my Inpatient or Outpatient claim be paid when there are several services on the claim including a *non-payable sterilization procedure*?**

Inpatient Claims

For hospitals that are paid either DRG or RCC:

HRSA is unable to exclude the sterilization service and pay the rest of the claim. Therefore, the entire claim is denied. **The hospital should submit a bill, excluding the sterilization diagnosis, procedure and associated sterilization costs from the bill.** The hospital should document in their claim file the reason the sterilization was not billed such as: “didn’t have consent form completed correctly.”

Outpatient Claims

For hospitals that are paid either OPPS or Per Charges:

HRSA is unable to exclude the sterilization service and pay the rest of the claim. Therefore, the entire claim is denied. **The hospital should re-bill, exclude the sterilization diagnosis, procedure and associated sterilization costs from the bill.** The hospital should document in their claim file the reason the sterilization was not billed such as: “didn’t have consent form completed correctly.”

How to Complete the Sterilization Consent Form, DSHS 13-364?

- All information on the Sterilization Consent Form, DSHS 13-364, must be legible.
- All blanks on the Sterilization Consent Form, DSHS 13-364, must be completed *except* race, ethnicity, and interpreter's statement (unless needed).
- HRSA does not accept "stamped" or electronic signatures.

The following numbers correspond to those listed on the Sterilization Consent Form, DSHS 13-364:

Section I: Consent to Sterilization	
Item	Instructions
1. Physician or Clinic:	Must be name of physician, ARNP, or clinic that gave client required information regarding sterilization. This may be different than performing physician if another physician takes over. <i>Examples: Clinic – ABC Clinic. Physician – Either doctor's name, or doctor on call at ABC Clinic.</i>
2. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
3. Month/Day/Year:	Must be client's birth date.
4. Individual to be sterilized:	Must be client's first and last name. Must be same name as Items #7, #12, and #18 on Sterilization Consent Form, DSHS 13-364.
5. Physician:	Can be group of physician or ARNP names, clinic names, or physician or ARNP on call at the clinic. This doesn't have to be the same name signed on Item # 22.
6. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
7. Signature:	Client signature. Must be client's first and last name. Must be same name as Items #4, #12, and #18 on Sterilization Consent Form, DSHS 13-364. Must be signed in ink.

(Continued next page)

8. Month/Day/Year:	<p>Date of consent. Must be date that client was initially counseled regarding sterilization.</p> <p>Must be more than 30 days, but less than 180 days, prior to date of sterilization (Item # 19). Note: This is true even of shorter months such as February.</p> <p>The first day of the 30 day wait period begins the day after the client signs and dates the consent form, line #8.</p> <p>Example: If the consent form was signed on 2/2/2005, the client has met the 30-day wait period on 3/5/2005.</p> <p>If less than 30 days, refer to page F.2/F.3: "When does HRSA waive the 30 day waiting period?" and section IV of Sterilization Consent Form, DSHS 13-364.</p>
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Section II: Interpreter's Statement

Item	Instructions
9. Language:	Must specify language into which sterilization information statement has been translated.
10. Interpreter:	Must be interpreter's name. Must be interpreter's original signature in ink.
11. Date:	Must be date of interpreter's statement.

Section III: Statement of Person Obtaining Consent

Item	Instructions
12. Name of individual:	Must be client's first and last name. Must be same name as Items #4, #7, and #18 on Sterilization Consent Form.
13. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
14. Signature of person obtaining consent:	Must be first and last name signed in ink.
15. Date:	Date consent was obtained.
16. Facility:	Must be full name of clinic or physician obtaining consent. Initials are acceptable.
17. Address:	Must be physical address of physician's clinic or office obtaining consent.

Section IV: Physician's Statement	
Item	Instructions
18. Name of individual to be sterilized:	Must be client's first and last name. Must be same name as Items #4, #7, and #12 on Sterilization Consent Form, DSHS 13-364.
19. Date of sterilization:	Must be more than 30 days, but less than 180 days, from client's signed consent date listed in Item #8. If less than 30 days, refer to page F.2/F.3: "When does HRSA waive the 30 day waiting period?" and section IV of the Sterilization Consent Form, DSHS 13-364.
20. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
21. Expected date of delivery:	When premature delivery box is checked, this date must be <i>expected</i> date of delivery. Do not use actual date of delivery.
22. Physician:	Physician's or ARNP's signature. Must be physician or ARNP who actually performed sterilization procedure. Must be signed in ink. Name must be the same name as on the claim submitted for payment.
23. Date:	Date of physician's or ARNP's signature. Must be completed either shortly before, on, or after the sterilization procedure.
24. Physician's printed name	Please print physician's or ARNP's name signed on Item #22.

How to Complete the Sterilization Consent Form for a Client Age 18-20

1. Use Sterilization Consent Form, DSHS 13-364(x).
2. Cross out "**age 21**" in the following three places on the form and write in "**18**":
 - a. Section I: Consent to Sterilization: "**I am at least 21...**"
 - b. Section III: Statement of Person Obtaining Consent: "**To the best of my knowledge... is at least 21...**"
 - c. Section IV: Physician's Statement: "**To the best of my knowledge... is at least 21...**"

Sample Sterilization Consent Form (DSHS 13-364)
(to be included prior to publication)

**Sample Sterilization Consent Form for a client age 18-20
(to be included prior to publication)**

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How to Complete the HCFA-1500 Claim Form

Note: HRSA encourages providers to make use of electronic billing options.
For information about electronic billing, refer to the *Important Contacts* section

The CMS-1500, HCFA-1500, U2, 12-90, or the Health Insurance Claim Form is a universal claim form. The numbered boxes on the claim form are referred to as fields. A number of the fields on the form do not apply when billing HRSA. Some field titles may not reflect their usage for a particular claim type.

If you do not follow these instructions, your claims may be denied or suspended for further processing, also known as adjudication. Either one of these actions will extend the time period between initial submission and final adjudication.

Guidelines/Instructions for Paper Claim Submission:

- **Use only the original preprinted red and white CMS-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner **cannot read** black and white (copied, carbon, or laser-printer generated) CMS-1500 claim forms.
- **Do not use red ink pens, highlighters, “post-it notes,” stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, “REBILL,” “TRACER,” or “SECOND SUBMISSION” or similar statements on claim form.
- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch). Do not mix character fonts on the same claim form. Do not use italics or script.
- **Use upper case** (capital letters) for all alpha characters.
- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not faded or too light!**
- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.
- **Place only six detail lines on each claim form.** HRSA does not accept “continued” claim forms. If more than six detail lines are needed, use additional claim forms.
- **Total each claim form separately.** Do not indicate the entire total (for all claims) on the last claim form. Do not indicate “continued” on claim forms.

HCFA 1500 Field Descriptions

Field No.	Name	Field Required	Entry
1a.	Insured's ID No.	Yes	<p>Enter the Patient Identification Code (PIC) – an alphanumeric code assigned to each HRSA client – exactly as shown on the Medical ID card which consists of the client's:</p> <ul style="list-style-type: none"> • First and middle initials (a dash [-] <i>must</i> be used if the middle initial is not available). • Six-digit birthdate, consisting of <i>numerals only</i> (MMDDYY). • First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker. • An alpha or numeric character (tiebreaker). • Apostrophes, hyphens and other special characters in a last name are valid and take the place of a letter. <p><i>For example:</i></p> <ul style="list-style-type: none"> ➤ Mary C. Johnson's PIC looks like this: MC010667JOHNSB. ➤ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B ➤ John O'Henry's PIC looks like this: J-102564O'HENA.
2.	Patient's Name	Yes	Enter the last name, first name, and middle initial of the client (the receiver of the services for whom you are billing).
3.	Patient's Birthdate	Yes	Enter the birthdate of the client.
4.	Insured's Name (Last Name, First Name, Middle Initial)		When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, TRI-CARE, or TRI-CAREVA) enter the name of the insured here. Enter the name of the insured except when the insured and the client are the same – then the word <i>Same</i> may be entered.
5.	Patient's Address	Yes	Enter the address of the client who received the services you are billing for (the person whose name is in Field 2.)

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Field No.	Name	Field Required	Entry
9.	Other Insured's Name		If there is other (secondary) insurance (Field 11d), enter the last name, first name and middle initial of the person who holds the other insurance. If the client has other insurance and this field is not completed, payment of the claim may be denied or delayed.
9a.	Other Insured's Policy or Group Number		Enter the other insured's policy or group number <i>and</i> insured's SSN.
9b.	Other Insured's Date of Birth and Gender		Enter the other insured's date of birth and gender.
9c.	Employer's Name or School Name		Enter the other insured's employer's name or school name.
9d.	Insurance Plan Name or Program Name		Enter the insurance plan name or program name (e.g., the insured's health maintenance organization, private supplementary insurance). Please note: DSHS, Medicaid, Welfare, Provider Services, Healthy Options, First Steps, and Medicare, etc., are inappropriate entries for this field.
10.	Patient's Condition Related To	Yes	Check <i>yes</i> or <i>no</i> to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in Field 24. Indicate the name of the coverage source in field 10d (L&I, name of insurance company, etc.).
11.	Insured's Policy Group or FECA (Federal Employees Compensation Act) Number		Primary insurance, when applicable. This information applies to the insured person listed in Field 4. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid is the payer of last resort.
11a.	Insured's Date of Birth		Primary insurance. When applicable, enter the insured's birthdate, if different from Field 3.
11b.	Employer's Name or School Name		Primary insurance. When applicable, enter the insured's employer's name or school name.
11c.	Insurance Plan Name or Program Name		Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. (Note: <i>This may or may not be associated with a group plan.</i>)

MAA-Approved Family Planning Providers

Field No.	Name	Field Required	Entry
11d.	Is there another Health Benefit Plan?	Yes if secondary insurance.	Required if the client has secondary insurance. Indicate <i>yes</i> or <i>no</i> . If yes, you should have completed Fields 9a.-d. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check <i>yes</i> . If 11d. is left blank, the claim may be processed and denied in error.
17.	Name of Referring Physician or Other Source		When applicable, enter the referring physician or Primary Care Case Manager (PCCM) name.
17a.	ID Number of Referring Physician		When applicable, 1) enter the 7-digit HRSA-assigned physician number. Refer to the Provider Number Reference website: http://pnrmaa.dshs.wa.gov ; 2) If the referring provider does not have an HRSA-assigned ID number, enter 8900946. Use this standard number only for referring providers who do not have an HRSA assigned ID number; or 3) When the PCCM referred the service, enter his/her 7-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this Field when you bill HRSA, the claim will be denied.
19.	Reserved for Local Use		This field is used for comments that require an HRSA claims specialist to review a claim before payment is made. Examples of appropriate comments: <ul style="list-style-type: none"> • “B” for baby on a parent’s PIC • “Twin A” or “twin B” • “Triplet A”, “triplet B”, or “triplet C” • “ITA client” • “NDC” • “backup attached” Inappropriate comments may result in delayed processing of claims.
21.	Diagnosis or Nature of Illness or Injury		Enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.
22.	Medicaid Resubmission		When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the <i>claim number</i> listed on the <i>Remittance and Status Report</i> .)
23.	Prior Authorization Number		When applicable. If the service or hardware you are billing for requires prior authorization, enter the assigned 9-digit number. (See Field 24K for Expedited Prior Authorization (EPA) numbers).

MAA-Approved Family Planning Providers

Field No.	Name	Field Required	Entry
24.	Enter only one (1) procedure code per detail line (Fields 24A - 24K). If you need to bill more than 6 lines per claim, please use an additional HCFA-1500 claim form.		
24a.	Date(s) of Service	Yes	Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., June 04, 2005 = 060405).
24b.	Place of Service	Yes	Enter the appropriate code as follows: <div style="display: flex; justify-content: space-between;"> <div> Code Number 11 31 32 </div> <div> To Be Used For Office Skilled Nursing Facility Nursing Facility </div> </div>
24d.	Procedures, Services or Supplies CPT/HCPCS	Yes	Enter the appropriate procedure code for the service(s) being billed. Modifier: When appropriate enter a modifier. If there is more than one modifier, begin the list of modifiers with "99" (e.g., 99 80 59)
24e.	Diagnosis Code	Yes	Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A valid diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume or relate each line item to Field 21 by entering a 1, 2, 3, or 4. The first diagnosis should be the principle diagnosis. Follow additional digit requirements per ICD-9-CM.
24f.	\$ Charges	Yes	Enter your usual and customary charge for the service performed. If billing for more than one unit, enter the total charge of the units being billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.
24g.	Days or Units	Yes	Enter the total number of days or units (up to 999) for each line. These figures must be whole units.
24k.	Reserved for Local Use		When applicable. Enter the required 9-digit EPA number only on the detail line to which the EPA number specifically applies.
25.	Federal Tax ID Number		Leave this field blank.

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Field No.	Name	Field Required	Entry
26.	Patient's Account Number		Not required (optional field for internal purposes). Enter an alpha or numeric character only. For example, a medical record number or patient account number. Do not enter spaces or the following characters in this field: * (asterisk) ~ (tilde) : (colon) This number will be printed on your <i>Remittance and Status Report (RA)</i> under the heading <i>Patient Account Number</i> .
28.	Total Charge	Yes	Enter the sum of all charges indicated in Field 24F. Do not use dollar signs or decimals in this field.
29.	Amount Paid		If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from a source(s) other than insurance, specify the source in Field 10d. Do not use dollar signs or decimals in this field or put prior Medicare or Medicaid payments here.
30.	Balance Due	Yes	Enter total charges minus any amount(s) in Field 29. Do not use dollar signs or decimals in this field.
33.	Physician's, Supplier's Billing Name, Address, Zip Code And Phone #	Yes	Enter the provider's <i>Name</i> and <i>Address</i> on all claim forms. PIN #: This is the seven-digit number assigned by HRSA to identify the performing individual when the individual is part of a group (e.g., the MD/ARNP, etc. who performed the service). Grp #: This is the seven-digit number assigned by HRSA to the billing entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made to this number. Note: When billing a Grp#, you must include a performing provider number in the PIN# field.

For questions regarding claims
information, call HRSA toll-free:

1-800-562-3022

HCFA 1500 Sample Scenario

Jane Doe was seen at ABC Family Planning Clinic (HRSA Family Planning Provider #7777777) on 6/12/05.

She received a Physical Exam (99203) which included a Pap Test (88150). An STD was suspected, so a Wet Mount (87210) was done.

Birth control options were discussed, a Pregnancy Test (84703) was done, and the client received a 6-month supply of Oral Contraceptives - Birth Control Pills (S4993).

The Pap Test was sent out to an independent lab (CLIA #06E3333333). They billed the clinic their usual and customary charge of \$10.00. The Wet Mount and Pregnancy Test were read onsite at the clinic.

The following is a sample claim for the services this client received, including billing for the test done at the independent lab.

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Health & Recovery Services Administration (HRSA)
Reproductive Health Services, Family Planning Only and Take Charge
Effective July 1, 2006

[Link To Legend For Code Status Indicator](#)

Code Status Indicator	Code	Modifier	Comments	Non-Facility Maximum Allowable Fee	Facility Maximum Allowable Fee	PA?	Global Days	Assist at Surg
	00840			6 Base	6 Base		000	N
	00851			6 Base	6 Base		000	N
R	11976			\$85.30	\$60.99		000	N
R	36415			\$2.49	\$2.49		000	N
R	36416			\$2.49	\$2.49		000	N
R	55250			\$350.37	\$132.54		090	N
R	55450			\$264.61	\$144.00		010	N
R	57170			\$57.78	\$30.73		000	N
R	58300			\$58.93	\$34.40		000	N
R	58301			\$63.06	\$43.34		000	N
	58565			#	#		090	N
R	58600			\$219.44	\$219.44		090	Y
R	58615			\$162.12	\$162.12		010	Y
R	58670			\$218.29	\$218.29		090	N
R	58671			\$218.52	\$218.52		090	N
	76075			PSBI	N/A		000	N
	76076			PSBI	N/A		000	N
R	76830	26		\$21.78	\$21.78		000	N
R	76830	TC		\$37.61	\$37.61		000	N
R	76830			\$59.39	\$59.39		000	N
R	76856	26		\$21.78	\$21.78		000	N
R	76856	TC		\$37.61	\$37.61		000	N
R	76856			\$59.39	\$59.39		000	N
R	76857	26		\$11.92	\$11.92		000	N
R	76857	TC		\$41.27	\$41.27		000	N
R	76857			\$53.20	\$53.20		000	N
	76977			PSBI	N/A		000	N
R	80061			\$15.35	\$15.35		000	N
	80076			\$7.32	\$7.32		000	N
	81000			\$3.63	\$3.63		000	N
	81001			\$3.63	\$3.63		000	N
	81002			\$2.93	\$2.93		000	N
	81003			\$2.57	\$2.57		000	N
R	81025			\$4.31	\$4.31		000	N
	82120			\$1.92	\$1.92		000	N
	82465			\$4.99	\$4.99		000	N
	83718			\$9.38	\$9.38		000	N
	84132			\$5.26	\$5.26		000	N
	84146			\$22.21	\$22.21		000	N
	84443			\$19.18	\$19.18		000	N
R	84703			\$8.60	\$8.60		000	N
	85013			\$2.71	\$2.71		000	N
	85014			\$2.71	\$2.71		000	N

CPT codes and descriptions are copyright 2005
by the American Medical Association.

Health & Recovery Services Administration (HRSA)
Reproductive Health Services, Family Planning Only and Take Charge
Effective July 1, 2006

[Link To Legend For Code Status Indicator](#)

Code Status Indicator	Code	Modifier	Comments	Non-Facility Maximum Allowable Fee	Facility Maximum Allowable Fee	PA?	Global Days	Assist at Surg
	85018			\$2.71	\$2.71		000	N
	85025			\$8.91	\$8.91		000	N
	85027			\$7.41	\$7.41		000	N
R	86255	26		\$12.15	\$12.15		000	N
	86255			\$13.81	\$13.81		000	N
	86631			\$13.55	\$13.55		000	N
	86632			\$14.55	\$14.55		000	N
	86692			\$19.66	\$19.66		000	N
	86706			\$12.31	\$12.31		000	N
	87110			\$22.44	\$22.44		000	N
	87140			\$6.39	\$6.39		000	N
	87147			\$5.93	\$5.93		000	N
	87210			\$4.89	\$4.89		000	N
	87270			\$13.74	\$13.74		000	N
	87320			\$13.74	\$13.74		000	N
	87340			\$11.83	\$11.83		000	N
	87490			\$22.98	\$22.98		000	N
	87491			\$40.21	\$40.21		000	N
	87590			\$22.98	\$22.98		000	N
	87591			\$40.21	\$40.21		000	N
	87810			\$13.74	\$13.74		000	N
R	88141			\$13.53	\$13.53		000	N
	88142			\$28.31	\$28.31		000	N
	88143			\$28.31	\$28.31		000	N
	88147			\$15.90	\$15.90		000	N
	88148			\$21.23	\$21.23		000	N
	88150			\$14.76	\$14.76		000	N
R	88152			\$12.10	\$12.10		000	N
R	88153			\$12.10	\$12.10		000	N
R	88154			\$12.10	\$12.10		000	N
	88164			\$14.76	\$14.76		000	N
	88165			\$14.76	\$14.76		000	N
R	88166			\$12.10	\$12.10		000	N
R	88167			\$12.10	\$12.10		000	N
R	88174			\$29.53	\$29.53		000	N
R	88175			\$36.61	\$36.61		000	N
R	88300			\$12.84	\$12.84		000	N
R	88302	26		\$4.59	\$4.59		000	N
R	88302	TC		\$23.16	\$23.16		000	N
R	88302			\$27.75	\$27.75		000	N
R	90772			\$11.47	\$11.47		000	N
	99071	FP		\$2.00	N/A		000	N
R	99201		Clients 21 and older	\$25.00	\$16.07		000	N

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R	99201		Clients 20 and younger	\$34.30	\$22.05		000	N
R	99202		Clients 21 and older	\$44.13	\$31.63		000	N
R	99202		Clients 20 and younger	\$60.55	\$43.40		000	N
R	99203		Clients 21 and older	\$65.82	\$48.72		000	N
R	99203		Clients 20 and younger	\$90.30	\$66.85		000	N
R	99204		Clients 21 and older	\$92.86	\$72.19		000	N
R	99204		Clients 20 and younger	\$127.40	\$99.05		000	N
R	99205		Clients 21 and older	\$118.11	\$96.43		000	N
R	99205		Clients 20 and younger	\$162.05	\$132.30		000	N
R	99211		Clients 21 and older	\$14.80	\$6.12		000	N
R	99211		Clients 20 and younger	\$20.30	\$8.40		000	N
R	99212		Clients 21 and older	\$26.28	\$16.33		000	N
R	99212		Clients 20 and younger	\$36.05	\$22.40		000	N
R	99213		Clients 21 and older	\$35.71	\$23.98		000	N
R	99213		Clients 20 and younger	\$49.00	\$32.90		000	N
R	99214		Clients 21 and older	\$56.12	\$40.05		000	N
R	99214		Clients 20 and younger	\$77.00	\$54.95		000	N
R	99215		Clients 21 and older	\$81.38	\$64.03		000	N
R	99215		Clients 20 and younger	\$111.65	\$87.85		000	N
	A4261			\$47.00	N/A		000	N
	A4266			\$30.87	N/A		000	N
	A4267			AC	N/A		000	N
	A4268			AC	N/A		000	N
	A4269			AC	N/A		000	N
	A4931	FP		\$7.91	N/A	EPA	000	N
R	G0101			\$22.93	\$14.68		000	N
R	J0456			\$20.23	\$20.23		000	N
R	J0580			\$42.10	\$42.10		000	N
R	J0690			\$1.34	\$1.34		000	N
R	J0694			\$6.91	\$6.91		000	N
R	J0696			\$2.03	\$2.03		000	N
R	J0697			\$1.46	\$1.46		000	N
	J0698			\$4.35	\$4.35		000	N
	J0710			\$1.41	\$1.41		000	N
R	J1055			\$53.05	\$53.05		000	N
	J1890			\$8.64	\$8.64		000	N
R	J2460			\$0.94	\$0.94		000	N
R	J2510			\$8.72	\$8.72		000	N
R	J2540			\$0.68	\$0.68		000	N
R	J3320			\$30.08	\$30.08		000	N
	J3490			\$10.15	N/A	EPA	000	N
	J7300			\$380.00	N/A		000	N
	J7302			\$415.00	N/A		000	N

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	J7303			\$28.00	N/A		000	N
	J7304			\$4.00	N/A		000	N
	Q0144			AC	N/A		000	N
	S4993			\$17.00	N/A		000	N
	S9445	FP	Take Charge only	\$57.98	N/A		000	N
	T1023	FP	Take Charge only	\$5.18	N/A		000	N
	T5999	FP		\$3.75	N/A	EPA	000	N

Code Status Indicators

D = Discontinued Code
N = New Code
P = Policy Change
R = Rate Update

Modifiers In This Fee Schedule

26 = Professional Component
TC = Technical Component
FP = Family Planning

Legend

= Not Covered
AC = Acquisition Cost
N/A = Not Applicable
N = No
Y = Yes
PSBI = See fee schedule in Physician-Related Services Billing Instructions
EPA = Expedited Prior Authorization